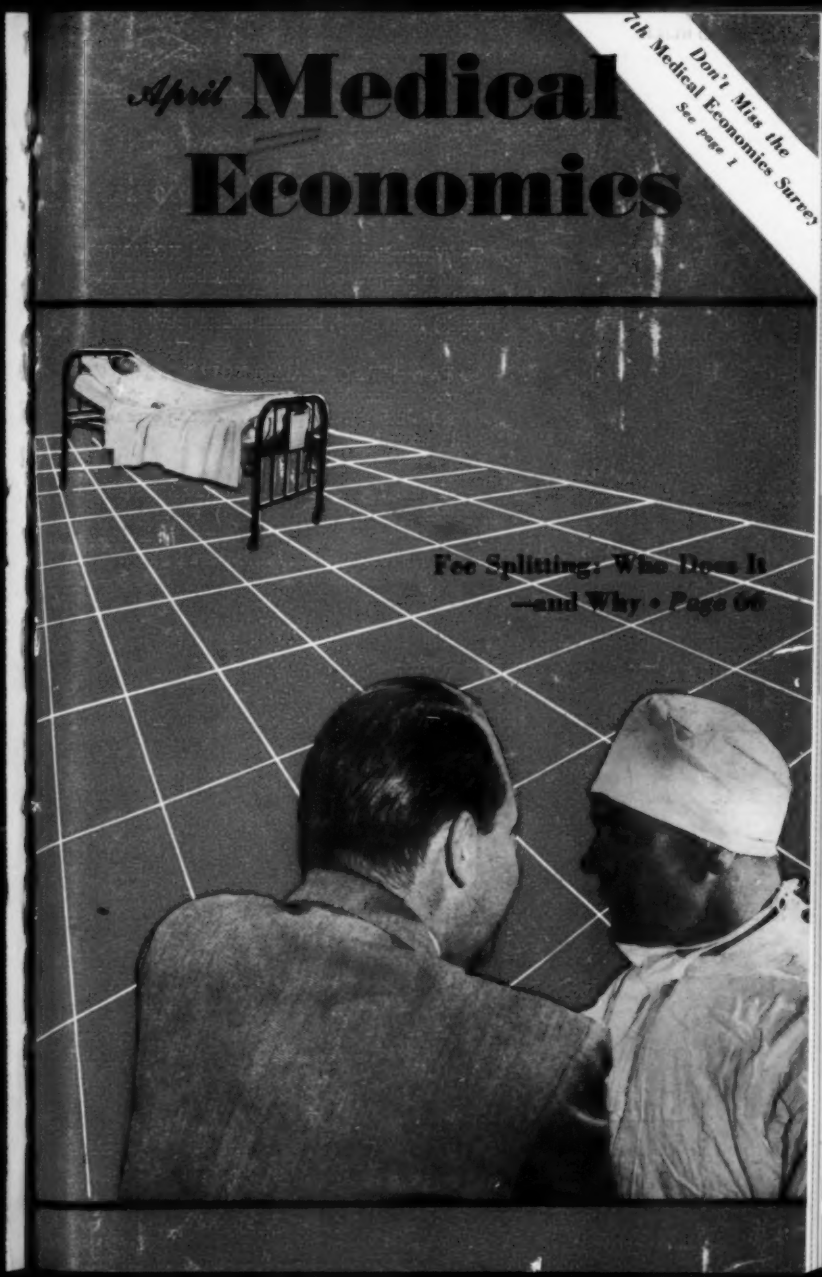
April Medical Economics
Don't Miss the 7th Medical Economics Survey
See page 1
Fee Splitting: Who Does It —and Why • Page 66

In treating peptic ulcer *it is important*

1. ***To Neutralize Hyperacidity.*** And KOLANTYL includes a superior antacid combination (magnesium oxide and aluminum hydroxide, also a specific antipeptic) for two-way, balanced antacid activity.

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1. Meyer, K. Am.J.Med. 5:482,1948.
2. Wang, K.J. and Grossman, M.I. Am.J.Phys. 155:476,1948.
3. Grace, W.J. Am.J.Med.Sc. 217:241,1949.
4. Hufford, A.R. Rev. of Gastroenterology. Aug.,1951.

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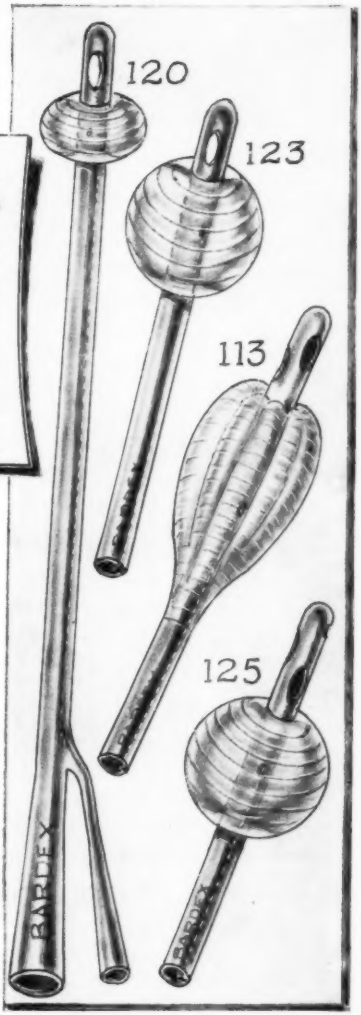

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113 Bardex Hemostatic Catheter, 75cc ovoid shape balloon: Even sizes only, 16 to30

125 Bardex Hemostatic Catheter, Return Flow 30cc balloon: Even sizes only, 18 to 26

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Medical Economics

* * * *April 1952* * * *

A PERSONAL INVITATION FROM THE EDITORS

DEAR DOCTOR:

This issue offers you an opportunity that comes only once every few years—an opportunity to measure your own economic performance against that of physicians the country over.

The Seventh MEDICAL ECONOMICS Survey, which is now under way, is the most comprehensive yet attempted. It will turn up a wide variety of facts not available elsewhere—including data on physicians' working hours, expenses, political views, investments, fees, assistants, income, and patient load. Results will be broken down by specialty, community size, years in practice, etc.

The Seventh MEDICAL ECONOMICS Survey questionnaire has been sent by separate mail to a cross-section totaling about one-third of the country's active, private physicians. If you have received one of the mailed questionnaires, we urge you to fill it in and return it promptly. *If you have not received one by mail, please fill in the copy of the questionnaire on the following pages.*

In either case, you need *not* identify yourself, *nor can the questionnaire be identified with you in any way.* Simply fill in for statistical use the requested facts about yourself and your practice. These facts will help us to present economic data in which you, as a private physician, have a vital and direct interest.

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The Seventh MEDICAL ECONOMICS Survey Questionnaire

	Cols.
1. I practice in the state of _____	5
2. Number of years in practice _____	6
3. Population of my community:	7
Under 5,000 ☐ 50,000-499,999 ☐	8
5,000-49,999 ☐ 500,000-999,999 ☐	
1,000,000 or over ☐	9
4. I practice (check one): Solo ☐ Full time in partnership or group ☐	10
5. I am (check one): G.P. ☐ Partial specialist ☐ Full specialist ☐	11
6. My specialty is: ALR ☐ Derm. ☐ Int. Med. ☐	12
N.P., Psy. ☐ OALR ☐ Ob., Gyn. ☐ Ophth. ☐	
Ortho. ☐ Ped. ☐ Rad., Roent. ☐ Surg. ☐	13
Urol. ☐ Other _____	
7. My sex: Male ☐ Female ☐	14
8. My *individual gross* income from *non-salaried* practice, 1951 (full year) _____ $_____	15-20
9. My *individual* income from *salaried* practice, 1951 (full year) _____ $_____	21-26
10. My *total* individual gross income from all types of medical practice, 1951 (*sum of Items 8 and 9*) _____ $_____	27-32
11. Office rent, 1951 (full year), cost me _____ $_____	33-37
12. Office salaries, 1951 (full year), cost me _____ $_____	38-42
13. Auto expenses (professional only), 1951 (full year), totaled _____ $_____	43-47
14. Drugs and supplies, 1951 (full year), cost me $_____	48-52
15. Instruments and equipment, 1951 (full year), cost me _____ $_____	53-57
16. All *other* professional expenses, 1951 (full year), amounted to _____ $_____	58-62
17. MY 1951 PROFESSIONAL EXPENSES (*sum of Items 11-16*) TOTALED _____ $_____	63-67
18. MY 1951 INDIVIDUAL *NET* INCOME FROM *NON-SALARIED* PRACTICE, BEFORE TAXES, WAS (*Item 8 minus Item 17*) _____ $_____	68-73

Please cut out these two pages and mail immediately (in a sealed envelope)

If you cannot furnish exact figures, please give estimates. Disregard numbers under the heading "Cols." They are for statistical purposes only.

	Cols.
19. MY INDIVIDUAL *NET* INCOME FROM ALL TYPES OF MEDICAL PRACTICE, 1951, BEFORE TAXES (*Item 10 minus Item 17*) $_____	74-79 80-x
20. I collected about——% of what patients owed me in 1951	5-6
21. I gave about——hours weekly to charity patients in 1951	7-8
22. I made charitable donations in 1951 totaling $———	9-12
23. To the *actual practice* of medicine I devote about ——hours a day; about——hours a week	13-14
24. I see about———patients a day in the office;	15-16
about———patients a day in the hospital;	17-18
about———patients a day in their homes	19-20
Total:———	
25. I dispense about———% of the medicines I tell my patients to take	21-22
26. I wrote prescriptions in 1951 totaling about———in number	23-26
27. I carry life insurance worth (principal amount) $———	27-32
28. I own about$———worth of real estate	33-38
29. I have about$———invested in stocks and/or bonds	39-44
30. I charge: For an office call $——; late night call, $——; daytime house call, $———	45-46 47-48 49-50
31. In 1948 my fee for an office call was $———	51-52
32. Should Social Security coverage be extended to private physicians? My answer is: Yes ☐ No ☐	53
33. Blue Shield and other health insurance plans pay me about——% of my total gross income (*Item 10*)	54-55
34. I consider myself a Republican ☐ Democrat ☐ Independent ☐ Other———	56
35. I employ——(number) *full-time* office aides (secretaries, technicians, etc.) at an average weekly salary of $——— each (before deductions)	57-58 59-61
36. I employ——(number) *part-time* office aides (secretaries, etc.)	62-63

Survey Editor, Medical Economics, Inc., Box 128, Rutherford, New Jersey

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or resistant organisms

make you hesitate to use

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Medical Economics

* * * *April 1952* * * *

[CONTINUED ON FOLLOWING PAGE]

Contents [*Continued*]

DEPARTMENTS

CCA

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elevates the mood	dl-desoxyephedrine hydrochloride . . . . . effective antidepressant and stimulant	1 mg.
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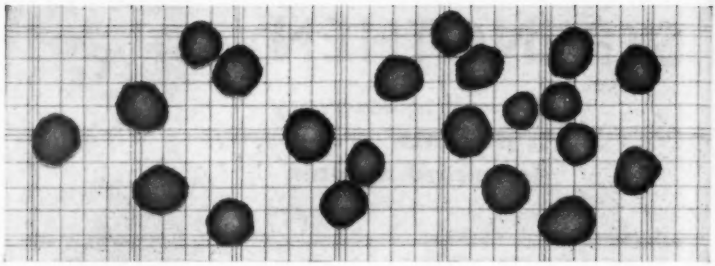

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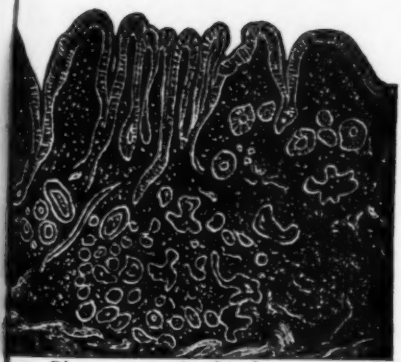

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1 Schoenheimer, R., Ratner, S., and Rittenberg, D., J. Biol. Chem., 127:333, 1939 and 130:703, 1939.

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Panorama

If physicians don't stop being "apathetic toward arthritis," the nation's 7.5 million arthritics may spearhead a new drive for socialized medicine. So warns Gen. George C. Kenney, president of the Arthritis and Rheumatism Foundation . . . About a hundred unlicensed dentists are being hunted in New Jersey. Specializing in cut-rate extractions, they split fees with referring bartenders . . . There's a brand-new item in the new Federal health budget: a quarter-million dollars to help states set up water fluoridation programs.

At last count, the Pennsylvania Blue Shield plan, sponsored by that state's physicians, had 551 participating osteopaths . . . As a precaution against a "biological Pearl Harbor," the Public Health Service is now asking local health officers for flash reports on "any unusual occurrence of diseases" . . . When John Willaman quit his job as a Cincinnati morgue attendant, he also gave up a strange hobby: He's accumulated more than 65,000 gallstones, kidney stones, and other calculi . . . One out of every four Canadian medical graduates enters practice in the U.S., reports Dr. H. G. Weiskotten of the A.M.A.

Stork Derby: The feature race at Florida's Sunshine Park recently was entitled the South Atlantic Association of Obstetricians and Gynecologists Handicap. The doctors for whom the horses ran were meeting (presumably) in near-by Belleair at the time . . . Mailing of medicine to persons in Russia and her satellite countries should be prohibited, says Rep. Louis B. Heller (D., N.Y.), who has introduced a bill to that effect. He reports that private parcels containing penicillin, aureomycin, and other drugs have been confiscated by the governments of Hungary and Rumania . . . Doctors' Day: When Dr. J. I. Morris was

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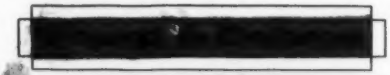


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Tablets

knocked down by a car in Marianna, Ark., he found himself looking up at Dr. F. S. Dozier, the driver. Witness to the accident: Dr. H. D. Bogart. Provider of first aid: Dr. W. C. Hays Jr.

Does cancer publicity create a disease phobia? Not so, says Dr. Brewster S. Miller of the American Cancer Society. Of a group of psychiatrists polled, he reports, only 8 per cent thought such publicity harmful . . . Called to a Los Angeles theatre some months ago, Dr. Herschel Burston found no patient but plenty of other physicians. He has now brought suit against Singer Josephine Baker, who, suffering from laryngitis, had placed a number of calls to ensure prompt attention. Upon arrival, Dr. Burston was told he'd be paid anyway—but hasn't been . . . What's a vurgeon? According to the Minneapolis Star, it's "a surgeon who has never performed an operation."

Do faddists foil physicians? Not always: After a newspaper article by food faddist Gayelord Hauser hailed the "blessings of plastic surgery," the Washington State Medical Association heard from many Hauser-readers who wanted names of reputable plastic surgeons . . . New interest in general practice has resulted in a General Practice Society, organized by medical students at the University of Pennsylvania. They think the movement may spread to other campuses . . . The Army has the legal right to draft doctors and use them in nonmedical jobs, even as dishwashers. Commenting on this possibility, the Philadelphia Inquirer editorializes: "The Army should not have that right, even though—so far—it hasn't been exercised. Only a doctor's wife should be clothed with such drastic powers!"

New York's up-and-coming tri-county (Oneida, Herkimer, and Madison) medical societies have put out a brochure telling the public why mediation committees are important and how to use them . . . Don't try to influence state legislators by showering them with mail, advises President Louis W. Jones of the Pennsylvania medical society. Such mail irritates them and pays poor dividends, he says, whereas a personal chat can often accomplish a great deal.

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Speaking Frankly

Reviewing

SIRS: The reviewing of medical books is in a deplorable state. Medical books usually require years of work and an investment of thousands of dollars; yet they are taken for granted by most medical journals, which gladly receive large numbers of them for review—and then proceed to neglect them.

Most medical journals are months, or even years, behind in their reviewing. Many irrelevant books, as well as later editions of old ones, are reviewed to the exclusion of new books that deserve immediate notice.

Thus, in the New England Journal of Medicine for Sept. 13, 1951, twenty-two out of the twenty-nine books reviewed were published back in 1950; in the September, 1951, American Journal of Psychiatry, five 1949 books and twelve 1950 books were reviewed; and the September, 1951, American Journal of Surgery contains no reviews at all. Most journals in September were still reviewing the twenty-second edition of a medical dictionary. These are random examples, but they're typical.

Well, what of it? Just this: Since the medical profession has abandoned its writers, a new educational influence has appeared. I speak of the book wholesaler who sells medical books like any other article of commerce. The wholesaler now prints the freshest and newest reviews and claims that they've been written by "authorities."

Many of these "authorities" sound suspiciously like book salesmen to me—but the medical profession deserves this sort of treatment. When will it back up its own authors?

M.D., California

From a Secretary

SIRS: My heartiest congratulations on "Letters to a Doctor's Secretary." Believe me, it certainly would have been nice to have something like this to refer to when I first began work in a physician's office.

Sarah Jane Huff, R.N.
Charleston, W.Va.

Instruments

SIRS: I read your article "The Surgical Instrument Business" [December, 1951] with great interest. Nobody gripes more about the cost of surgical instruments than I do.

What the article failed to mention is how much the instrument manufacturer gets for the hemostat that costs me $7. I hope I am mistaken, but I think there's a big dif-

ference between what he gets and what I pay.

Raymond H. Barker, M.D.
Coeur d'Alene, Idaho

According to a spokesman for the surgical instrument business, about 60 per cent of the retail cost of most medical instruments goes to the manufacturer. The remaining 40 per cent goes to the distributor or surgical supply dealer who stocks, sells, and services the item. (This 60-40 ratio, incidentally, is about the same as that prevailing for most goods sold at the retail level in department and other stores throughout the country.)

SIRS: In your article on surgical instruments you make the following statement: "What's in it for the inventor? A lot of personal satisfaction, some prestige, and the knowledge that he's made a contribution to medicine—but, for ethical reasons, no money."

Five years ago I designed a mouth gag for tonsillectomy that has since completely replaced other types previously in use in this area. I submitted this instrument to several manufacturers who did not see its virtues and who—very kindly but very firmly—turned it down.

I did not seek gain for myself. But, feeling confident of the value to the profession of this instrument, I set up a company to manufacture and distribute it.

Am I running the risk of being unethical in operating this business?

If so, it seems to me that ethics are being stretched a bit too far. Doctors receive royalties from medical books and engage in all manner of business activity for profit. But let a doctor discover a new drug or develop a new instrument on which he makes a profit, and he immediately becomes unethical.

So far, I continue to be strictly ethical in my business venture, since I have operated at a loss each year. I hope the fun and satisfaction I have enjoyed haven't put too much of a strain on my morality.

Robert J. McIvor, M.D.
Oakland, Calif.

A Common Goal

SIRS: There are a couple of things I'd like to talk about in your hospitable columns:

1. In my opinion, the A.M.A. should stop trading political blows with Mr. Ewing and start promoting the voluntary prepaid plans with more enthusiasm and with better spirit. A lot of work must be done in figuring out ways to increase coverage with fewer restrictions on services rendered. If the profession and the A.M.A. got solidly behind medical and hospital insurance, such plans could meet most of the needs of the average-income individual both over and under age 65.

2. Let's stop boasting about the wonders of American medicine and look at its shortcomings. The high standards often cited may not apply

to all of us. For example, Dr. Norman Miller has shown how frequently unindicated pelvic surgery is now performed. In 1947, I showed that unindicated surgery could occur even in the service of a university hospital (Indications for Removal of a Normal Uterus; Amer. J. Obst. & Gynec.; 54; p. 321). Recently, I discussed this problem with a foreign doctor who's over here to study American surgery. He said he had seen many cases of unindicated surgery during his stay here. He felt that competition between surgeons is largely responsible and that an attitude of "If I don't operate, someone else will" seems to prevail. In his country, he added, the shortage of hospital beds would make such surgery a serious offense.

If we are going to convince the public that we can do the job without Mr. Ewing's help, we had better settle the differences within the profession and ferret out the dishonest in our midst. The common goal upon which we all can agree is that of practicing good medicine.

When the politicians convince the public that organized medicine is not maintaining the highest standards, then we shall be doomed to Government supervision.

Roland Bieren, M.D.
Washington, D.C.

The Eyes Have It

SIRS: Ninety per cent of the people don't know the difference between an ophthalmologist, an oculist, an optometrist, and an optician. The discouraging part is that the

medical societies will not do anything to clear up this confusion.

I suggest that we, the opthalmologists, start calling ourselves "Eye Physicians." It would be a most important help to understanding; and it wouldn't be long before the people, the press, and the rest of the profession made the designation "Eye Physician" a permanent part of our professional language.

John V. McMackin, M.D.
Miami, Fla.

Holding the Bag

SIRS: There are occasions when a physician, after waiting a long time for a check from an insurance company for treatment of an insured patient, finally contacts the insurance company—only to find that it has paid the patient some weeks before. Then the trouble really begins.

By the time the physician gets to the patient, the insurance money has been spent for something like a new television set, and the patient has no money left. The insurance company has carried out its obligation under the terms of the policy, and the doctor is left holding the bag (as usual).

Does anyone have any ideas on this matter?

Edward B. Tyson, M.D.
Ocean City, N.J.

Is 'Negro' Necessary?

SIRS: I have observed that MEDICAL ECONOMICS follows the Southern newspaper custom of automatically using the tag words "colored" or "Negro" in crime news in which Negroes are involved.

The most recent example turns up in a news item about a doctor winning three bouts with hold-up men. In bout No. 1 the criminals are "two Negro thugs," while in the other encounters the assailants are described as "two men" and as "a man."

Is the racial labeling in the first case pertinent to the story?

Henry A. Washington, M.D.
Syracuse, N.Y.

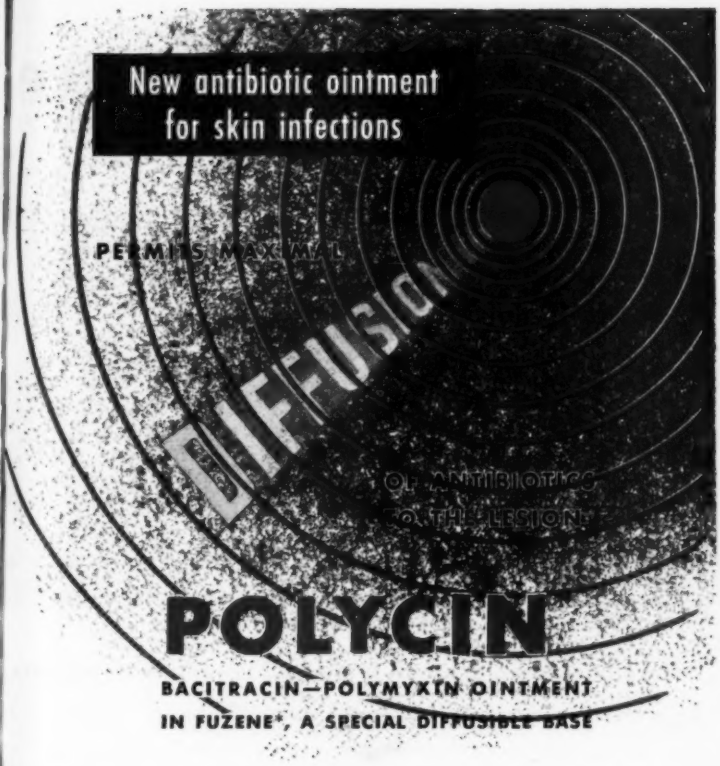
The editors of MEDICAL ECONOMICS *agree with Dr. Washington that the label in this case was not pertinent to the story. Henceforth, such labels will be included only when essential.*

Chemists

SIRS: My attention has been called to a news item in MEDICAL ECONOMICS, entitled "Chemists Fight Doctors on Lab Procedure." The item states that chemists in Pennsylvania tried to "cannonball one of their pet bills through the state legislature"—a bill that would have permitted "only specially trained M.D.'s or scientists to do clinical laboratory analyses."

Actually, the chemists did not undertake to cannonball any bill through the Pennsylvania (or any other) legislature. It was the representatives of the M.D.'s who tried to do so. You simply attribute "cannonballing" to the wrong group.

The American Chemical Society



Polycin combats both gram-positive and gram-negative organisms. Its action over a wide antibacterial spectrum is enhanced by its unique *Fuzene* base.

This original combination of carbowax diesters and petrolatum allows *maximal diffusion* of Polycin's bacitracin and polymyxin content. The antibiotics . . . both notable for a low incidence of sensitization and for demonstrated effectiveness in skin infections . . . are brought into intimate contact with organisms in the lesion.

Polycin is supplied in 15 Gm. tubes. Clinical samples and literature are available on request.

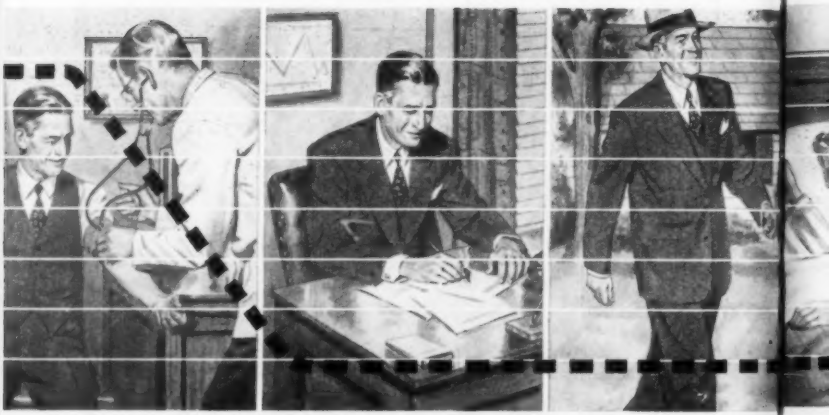
PITMAN-MOORE COMPANY

Division of Allied Laboratories, Inc.

Indianapolis 6, Indiana

*TRADE MARKS

Isn't this the picture y



Nitranitol's safe, gradual, prolonged vasodilation permits hypertensives to resume more normal lives

What's more, therapeutic dosages of NITRANITOL can be maintained over long periods of time . . . *without* frequent checkups . . . *without* worry about possible toxic effects.

Is it any wonder that NITRANITOL is the universally prescribed drug in the management of essential hypertension?

Merrell
1828

New York • CINCINNATI • Toronto

re you want to prescribe..

for your hypertensive patients

When vasodilation alone is indicated. *Nitranitol.* (½ gr. mannitol hexanitrate.)

When sedation is desired. *Nitranitol with Phenobarbital.* (½ gr. phenobarbital combined with ½ gr. mannitol hexanitrate.)

For extra protection against hazards of capillary fragility. *Nitranitol with Phenobarbital and Rutin.* (Combines 20 mg. rutin with above formula.)

When the threat of cardiac failure exists. *Nitranitol with Phenobarbital and Theophylline.* (½ gr. mannitol hexanitrate combined with ½ gr. phenobarbital and 1½ grs. theophylline.)

NEW . . . For refractory cases of hypertension. *Nitranitol P.V.* (½ gr. mannitol hexanitrate combined with ½ gr. phenobarbital and 1 mg. Veratrum viride alkaloidal fraction – biologically standardized for hypotensive activity.)

NITRANITOL®

has opposed for years the type of legislation that would provide a legal monopoly to M.D.'s in the clinical laboratory field. It believes the direction of clinical laboratories must be in the hands of competent individuals and that a degree, whether an M.D. or some other, does not *per se* establish the competence of an individual to conduct, supervise, and report on the results of intricate clinical experiments or determinations.

The society has always made it clear that these functions just described are totally different from the *interpretation* of clinical results in the treatment of a patient, and that such interpretation should rest solely with the physician.

An editorial in the August 20, 1951, issue of Chemical and Engineering News, which I edit for the American Chemical Society, states the position of the society quite clearly. It reads, in part, as follows:

"The American Chemical Society, in the interest of the public, will continue (1) to insist that charlatans, no matter what degree they hold, be eliminated from the field of clinical chemistry; (2) will continue to fight the creeping aggression of the medical profession seeking to drive out of clinical chemistry all those who do not possess an M.D. degree, regardless of their qualifications to perform such work in a scientific and professional manner."

Walter J. Murphy
Washington, D.C.

Just TOUCH AND GO *lightly!*

IBM

Electric Typewriters

With a touch of her fingertips your secretary turns out beautiful work on an IBM Electric. It's such an *easy* typewriter to use.

Quickly, almost effortlessly, she types your letters, case histories, reports, bills . . . each uniformly clear, distinctive. IBM Electric typing is strikingly different.

For brochure telling about this time-saving typewriter, write to IBM, Dept. MC-1, 590 Madison Avenue, New York 22, N. Y.

INTERNATIONAL BUSINESS MACHINES

New! For Prompt Relief of Cough

A single bedtime dose often provides night-long freedom from sleep-robbing "night cough"

PHENERGAN EXPECTORANT

gives your patients the combined benefits of Phenergan, the long-acting antihistaminic that has pronounced local anesthetic action, PLUS an effective, time-tested sedative-expectorant prescription formula.

- Local anesthetic effect
  —soothes irritated mucosa
- Antihistaminic effect
  —reduces congestion
- Direct antitussive effect
  —curbs cough reflex
- Sedative-expectorant effect
  —promotes "easy" expectoration

Agreeably Flavored

PHENERGAN®

EXPECTORANT With Codeine*

Promethazine Expectorant with Codeine WYETH

Supplied in bottles of 1 pint. Literature to physicians on request.

Wyeth®

[illegible] Philadelphia 2, Pa.

Decades rather than days . . . .

. . . measure the progress of gallbladder trouble. Dyspepsia, flatulence, or constipation are often the early signs, foreshadowing far graver disorders. *Rational* biliary therapy therefore should include functional as well as symptomatic relief, from the very beginning.

Zilatone®—*a rational formulation—provides . . .*

BILE SALTS—most effective known choleretic—mediating fat and fat-soluble-vitamin absorption, stimulating bowel motility, and inhibiting intestinal putrefaction. — ***to improve biliary function***

MILD LAXATIVES, supplementing the gentle corrective action of the bile salts, encouraging peristalsis without spasm. — ***to relieve constipation***

TONICS AND DIGESTANTS of tested value in promoting the digestion, utilization, and enjoyment of food. — ***to promote digestive normalcy***

INDICATIONS: Dyspepsia, flatulence, constipation, and geriatric complaints attributable to biliary dysfunction; constipation of pregnancy; and nonobstructive cholecystitis.

SUPPLIED: Boxes of 20, 40, and 80 tablets and bottles of 500 and 1000.

Samples to physicians on request.

DREW PHARMACAL CO., INC.
1450 Broadway • New York 18, N. Y.

NEUTRALIZE EXCESS STOMACH ACIDITY

but maintain protein digestion

A common problem is that of relieving gastric acidity without retarding gastric digestion.

Al-Caroid provides a ready answer. Here in a single, balanced formula are 3 effective antacid ingredients with added bismuth salts to soothe and protect the gastric mucosa. Al-Caroid acts quickly, provides a sustained action.

In addition, Al-Caroid contains the potent proteolytic enzyme, "Caroid," from the tropical tree, Carica Papaya. Unlike animal enzymes or ferments, "Caroid" functions in acid as well as alkaline media.

Al-Caroid speeds the digestion and assimilation of needed proteins, dissolves excessive mucus and relaxes the spasmodic pylorus.

Tablets, in bottles of 20, 50, 100, 500 and 1000.
Powder, in packages of 2 oz., 4 oz., and 1 lb.

write for professional samples

al-caroid®
POWDER AND TABLETS

ANTACID
DIGESTANT

AMERICAN FERMENT COMPANY, INC.
1450 Broadway • New York 18, N. Y.

Before Use of Riasol

After Use of Riasol

APRIL *Looking Ahead* JUNE

in

PSORIASIS *treated with* RIASOL

It may take about 8 weeks to clear up the ugly skin patches of psoriasis with RIASOL. To be exact, the statistical analysis of a series of severe cases treated with RIASOL showed disappearance or great improvement of the cutaneous lesions in periods ranging from 2 to 13 weeks, average 7.6 weeks.

Your patient, male or female, is looking ahead to the summer season. He or she may wish to wear bathing suits, shorts or slacks. It is a matter of great importance, therefore, to clear up the disfiguring skin patches with RIASOL as early as possible.

It is the deeper action of RIASOL, reaching the epidermal layers where the lesions originate, that is responsible for the speed of the therapeutic result.

RIASOL contains 0.45% mercury chemically combined with soaps, 0.5% phenol and 0.75% cresol in a washable, non-staining, odorless vehicle.

Apply daily after a mild soap bath and thorough drying. A thin, invisible, economical film suffices. No bandages required. After one week, adjust to patient's progress.

Ethically promoted RIASOL is supplied in 4 and 8 fld. oz. bottles, at pharmacies or direct.

MAIL COUPON TODAY—
TEST RIASOL YOURSELF

Dept. ME-3-5

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12850 Mansfield Ave.,
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Please send me professional literature and generous clinical package of RIASOL.

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RIASOL FOR PSORIASIS

1. IMMEDIATE
2. SUSTAINED
3. PROLONGED

reduction in blood pressure

Capsules *Ray-Trote* combine three supplementing therapeutic agents which serve to control high blood pressure with maximum efficiency. Capsules *Ray-Trote* introduce a timing element essential for the safest and most satisfactory control of hypertension.

Nitroglycerin: Because of its rapid vasodilating action, nitroglycerin reduces blood pressure almost instantaneously. To give the patient immediate relief, it still remains the drug of choice.

Sodium nitrite: Sodium nitrite is a somewhat slower acting vasodilator, and begins to take full effect as the action of nitroglycerin subsides.

Veratrum viride: Chemically standardized veratrum viride is probably the most active and reliable cardiac depressant.[1] Although slow to act, its depressant effect on blood pressure is prolonged, exceeding that of sodium nitrite by several hours.

Consequently, capsules *Ray-Trote* provide, in a single dosage form, immediate, sustained, prolonged hypotensive activity.

Phenobarbital: Capsules *Ray-Trote* also contain phenobarbital, to maintain a calmer, more restful hypertensive patient.

Dosage: One capsule every three or four hours. Discontinue use if pulse becomes abnormally slow, or patient complains of nausea.

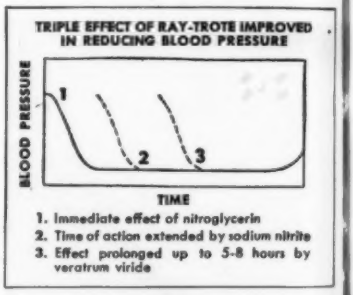
1. Sollman, T.: A Manual of Pharmacology, W. B. Saunders Co., 1942.

3-stage action
to control hypertension

Capsules

RAY-TROTE

Improved



Formula: Each capsule contains:

Nitroglycerin	0.25 mg.
Sodium Nitrite	30 mg.
Veratrum Viride (standardized to 1.0% alkaloid content)	65 mg.
Phenobarbital	15 mg.

Supplied in bottles of 100, 500 and 1,000 capsules. Also available, Capsules Ray-Trote with Rutin. *In addition to the* Ray-Trote *formula, each capsule contains Rutin, 20 mg.*

RAYMER

RAYMER PHARMACAL COMPANY

Pharmaceutical Manufacturers
Jasper and Willard Streets, Philadelphia 34, Pa.

SERVING THE MEDICAL PROFESSION FOR NEARLY A THIRD OF A CENTURY

To increase

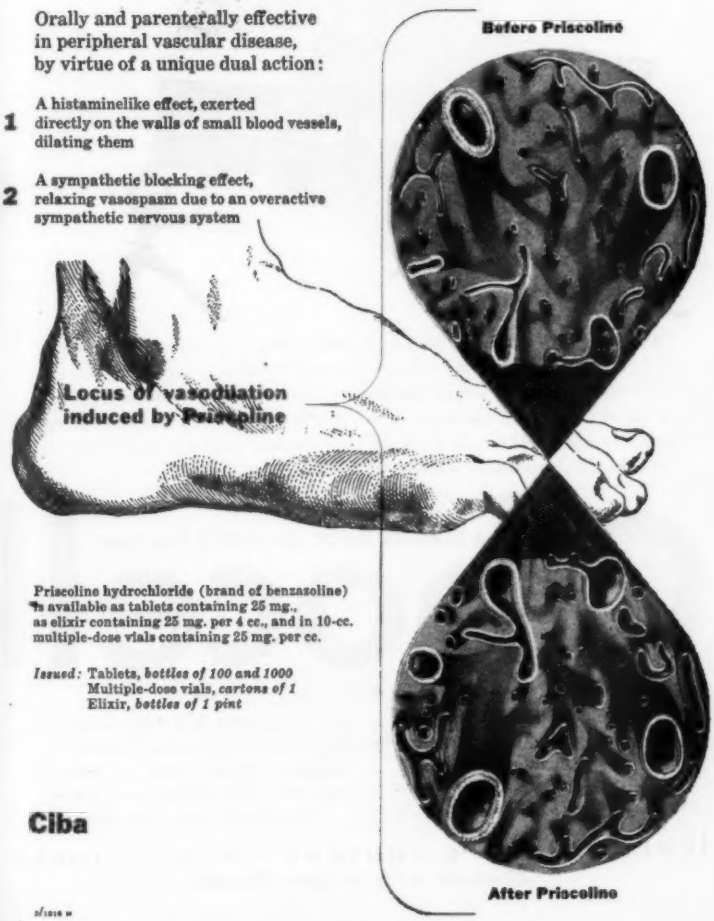
peripheral blood flow

Priscoline®

a potent vasodilator

Orally and parenterally effective in peripheral vascular disease, by virtue of a unique dual action:

1. A histaminelike effect, exerted directly on the walls of small blood vessels, dilating them
2. A sympathetic blocking effect, relaxing vasospasm due to an overactive sympathetic nervous system



Priscoline hydrochloride (brand of benzazoline) is available as tablets containing 25 mg., as elixir containing 25 mg. per 4 cc., and in 10-cc. multiple-dose vials containing 25 mg. per cc.

Issued: Tablets, *bottles of 100 and 1000*
Multiple-dose vials, *cartons of 1*
Elixir, *bottles of 1 pint*

Ciba

2/1018 M

Obocell greatly simplifies the ordeal of a reducing regimen in the management of obesity. The unique **double** action of Obocell (1) suppresses bulk (hollow) hunger and (2) curbs the appetite. Obocell also produces a feeling of well-being, thus combating fatigue and irritability which are commonly encountered when food is restricted. Patients on Obocell therapy eat less, do not violate their diet, lose weight and are satisfied and happy.

A COMBINED HUNGER AND APPETITE DEPRESSANT

Obocell®

Each Obocell tablet contains Dextro-Amphetamine Phosphate, 5 mg.; Methylcellulose, 150 mg.

Now available OBOCELL LIQUID . . . a new palatable syrup for patients who prefer liquid medication.

Dose: Obocell is given three times daily one hour before meals (3 to 6 tablets daily or 3 teaspoonfuls to 3 tablespoonfuls of liquid daily in a full glass of water).

Supplied: Obocell Tablets in bottles of 100, 500, 1000; Obocell Liquid in pints.

Professional Literature on Request

IRWIN, NEISLER & COMPANY • DECATUR, ILLINOIS

Research to Serve Your Practice

Sidelights

Profit Motive

It's fun to indulge in speculative comparisons between physicians and tradesmen. Elsewhere in this issue, we even do a bit of it ourselves (see "If Doctors Were Plumbers"). But let's remember that such comparisons must remain pure whimsey, because the two can't really be compared.

Why not? Because physicians live by an ethical code that subordinates the profit motive—which is, after all, the governing force in the world of business.

A recent report from Gary, Ind., illustrates the difference. A doctor there answered a young father's emergency call, took care of his sick child, and later billed the man for $4. When the bill went unpaid, the physician took his loss philosophically.

Some weeks later, the same young man appeared at the doctor's house to service a TV set. After a new tube had been installed, the doctor asked how much he owed. The young man replied, with evident embarrassment: "The new tube costs $2, but we have a service charge of $6 for making house calls, so altogether you owe me $8. And I'm afraid you'll have to pay right now—my orders are not to leave without the cash."

A difference in methods? You bet. And let's keep it that way.

Investment Risk

Investing in common stocks used to be looked on as a risky business. It still is. But doctors, among others, seem increasingly aware that *not* investing in such securities can also be risky.

Consider a man whose savings have been concentrated in bonds, bank accounts, and other "safe" investments. The real value of his holdings has shrunk drastically since inflation set in—so much so that he may now wonder whether such investments really *are* safe.

A wiser course during these times, as almost everyone knows by now, is to keep some savings where they'll rise with the tide—for example, in common stocks. If anyone needs to be convinced that this is the new "conservative" approach, he might take a look at what our endowed universities are doing.

The money managers of these institutions simply don't go in for unnecessary risks. Yet many of them now keep from half to two-thirds of all their endowment funds in common stocks. Here are some cases in

point, as reported recently by the firm of Vance, Sanders & Co.:

Name of Institution	% of Endowment Funds in Common Stocks
Cornell University	48%
Harvard University	49
Johns Hopkins University	46
Massachusetts Institute of Technology	62
Princeton University	50
Washington University	67

That's conservative investing, as the universities see it today. Not a bad bench mark for the rest of us.

Deflated Diplomate

Specialty-board certificates are nice things to have, a mark of professional achievement. But patients remain almost totally oblivious of such kudos. *Most* patients, that is.

Dr. Curtice Rosser of Dallas, a past president of the Southern Medical Association, tells about an exception. He came into his office one morning to find a new patient busily writing down all the intelligence to be gleaned from the black-framed diplomas on the wall. "At last!" thought Dr. Rosser, who belongs to an imposing number of specialty organizations. "Maybe those things are beginning to impress the public after all!"

It took only a few minutes to dispel the notion. The patient turned out to be in urgent need of a psychiatric referral. Dr. Rosser did the honors, meanwhile reverting to his good-humored conviction that "nobody pays any attention to all these fancy certificates." [*Turn page*]

it would take a troop of trailers

...To house all of the patients who represent each of the many conditions for which short-acting* NEMBUTAL *is effective.

YOU'D COUNT AT LEAST 44 PEOPLE, if you could see them all at once. For over 44 uses is the clinical record for short-acting NEMBUTAL since it was introduced in 1930.

Case after case from the 570 published reports shows that adjusted doses of short-acting NEMBUTAL can achieve any desired degree of cerebral depression—from mild sedation to deep hypnosis. *And this is accomplished with only about half the dosage required by many other barbiturates.*

Remember:
In equal oral doses, no other barbiturate combines QUICKER, BRIEFER, MORE PROFOUND EFFECT *than . . .*

The dosage is small, the margin of safety is wide. Note, too, the shorter duration of effect, the virtual freedom from cumulative effect and "hangover," the definite economy for your patient.

For your copy of the new booklet, "*44 Clinical Uses for* NEMBUTAL," write Abbott Laboratories, North Chicago, Ill. Perhaps it will suggest to you additional effective uses for short-acting NEMBUTAL in your practice. Abbott

Nembutal®
(PENTOBARBITAL, ABBOTT)

FOR INSOMNIA AND SIMPLE SEDATION
try the 50-mg. (¾-gr.)
NEMBUTAL *Sodium Capsule*

Which should remind us that ordinary patients—the sane ones—put little stock in paper qualifications. They are still looking for the physician who will contribute not only skill and knowledge, but *himself.*

Seal of Acceptance

Though it was published in the Journal A.M.A. back before Christmas, we haven't been able to shake the darn thing out of our mind. "Petting, Kissing, and Tuberculosis," the item was entitled. It started off with a query from a worried-sounding physician in Illinois: "What are the chances of contracting tuberculosis at parties at which there is the usual petting and kissing?"

In keeping with the holiday spirit, the Journal's answer threw conservatism to the winds: "The chances are little more than are encountered in daily life and there is a calculated risk in almost anything. Since man is a social creature, he must expect risks in social contacts, even in petting parties. The other alternative is to become a hermit or a bore . . ."

The game of post office thus seems to have been awarded the A.M.A. seal of acceptance. Will bundling be next?

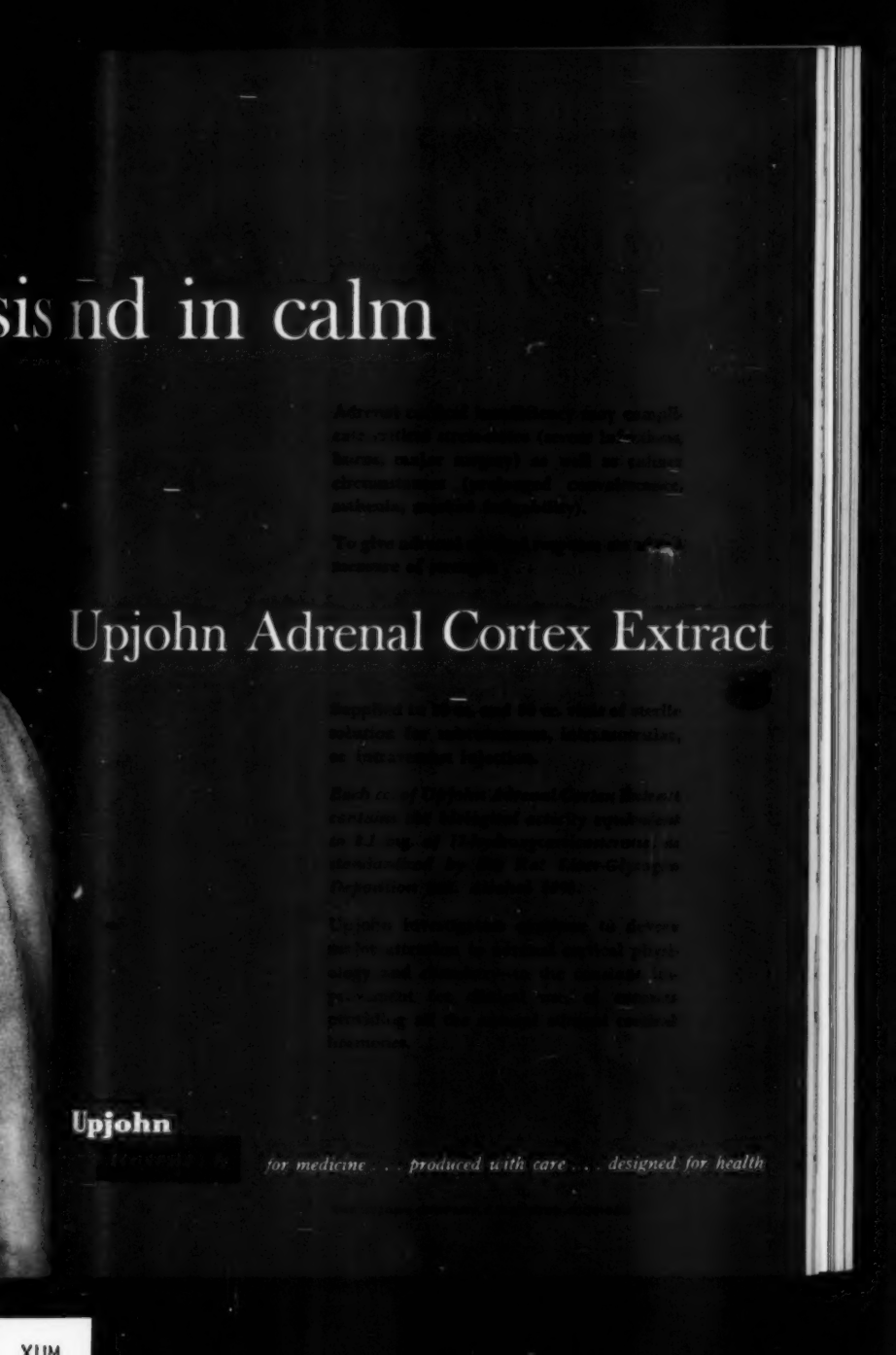
Eleazer Hornbostel Says

Just got back from th' annual meeting of th' American College of Abortionists. Not much popping this year; though they did pass a resolution adopting a new A.C.A. slogan: "No Fetus Can Beat Us!"

strength in crisis n

U

Up


sis nd in calm
Upjohn Adrenal Cortex Extract
Upjohn
for medicine . . . produced with care . . . designed for health

BACITRACIN-NASAL

CSC

HIGHLY EFFECTIVE
IN MANY UPPER RESPIRATORY INFECTIONS

In the local treatment of many upper respiratory infections the combined use of decongestant medication and bacitracin has proved of therapeutic as well as symptomatic efficacy.[1,2] Nasal ventilation is promptly improved, and—as many pathogens present in the nasal passages and sinuses are bacitracin-sensitive—the period of infection is reduced.[3]

Since bacitracin is virtually nonallergenic, adverse local reactions need not be feared.[1]

Bacitracin-Nasal-C.S.C., when reconstituted for use, presents 250 units of bacitracin per cc. and 0.25% *dl*-desoxyephedrine hydrochloride in a rose-scented, approximately isotonic aqueous solution. Since it is nonirritant, well tolerated, and pleasantly scented, it is acceptable to children as well as adults. It is indicated in acute and subacute sinusitis and in coryza when sinus involvement develops. Prophylactically, in early coryza it aids in the avoidance of secondary invasion.

Bacitracin-Nasal-C.S.C. is supplied in the dry state in 15 cc. bottles with accompanying dropper, and is to be reconstituted by the pharmacist just before being dispensed.

REFERENCES

1. Prigal, S.J.: Bacteriologic and Epidemiologic Approach to the Treatment of Respiratory Infections with Aerosols of Specific Antibiotics, Bull. N.Y. Acad. Med. *26*:282 (Apr.) 1951.
2. Stovin, J.S.: The Use of Bacitracin in the Treatment of Sinusitis and Related Upper Respiratory Infections, New York Physician *32*:14 (July) 1949.
3. Prigal, S.J., and Furman, N.L.: The Use of Bacitracin, a New Antibiotic in Aerosol Form; Preliminary Observations, Ann. Allergy 7:662 (Sept.-Oct.) 1949.

C.S.C. Pharmaceuticals

A DIVISION OF COMMERCIAL SOLVENTS CORPORATION, 17 EAST 42ND STREET • NEW YORK 17

in functional **G.I.** *distress*

though findings are negative, patients remain positive of their many symptoms – belching, flatulence, nausea, indigestion and constipation.

prompt and effective relief

can be given most of these patients by prescribing *Decholin/Belladonna* for alleviating spasm and stimulating liver function.

DECHOLIN® with BELLADONNA

reliable spasmolysis

The belladonna component of *Decholin/Belladonna* effectively relieves pain due to spasm and incoordinate peristalsis, and facilitates biliary and pancreatic drainage through relaxation of the sphincter of Oddi.

improved liver function

Dehydrocholic acid *(Decholin)*, the most powerful *hydro*choleretic known, increases bile flow, flushes the biliary tract with thin fluid bile and provides mild laxation without catharsis.

DOSAGE

One or, if necessary, two *Decholin/Belladonna* Tablets three times daily.

COMPOSITION

Each tablet of *Decholin/Belladonna* contains *Decholin* (brand of dehydrocholic acid) 3¾ gr., and ext. of belladonna, 1/6 gr. (equivalent to tincture of belladonna, 7 minims). Bottles of 100.

DB-1

AMES COMPANY, INC · ELKHART, INDIANA

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One simple way to promote GOOD NUTRITION

WHENEVER a worried mother asks you how to "make" her baby eat more, you can help her understand that a baby gets full benefit from his food when he *enjoys* it.

No baby can be expected to thrive nutritionally and emotionally if mealtimes are marred by coaxing and conflict.

It is fortunate for your young patients that Beech-Nut Foods combine fine nutritive values with appealing flavor. Now, with more varieties to choose from than ever before, Beech-Nut makes it easier for mothers to please your young patients and *keep* mealtimes happy!

A wide variety for you to recommend: Meat and Vegetable Soups, Vegetables, Fruits, Desserts—*Cooked* Cereal Food, *Strained* Oatmeal and *Cooked* Barley.

Babies love them... thrive on them!

Beech-Nut
FOODS *for* BABIES

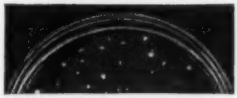
ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

Every Beech-Nut Baby Food has been accepted by the Council on Foods and Nutrition of the American Medical Association and so has every statement in *every* Beech-Nut Baby Food advertisement.

4 ways in which Hexachlorophene in

DIAL SOAP protects you and your patients

Photomicros show how Dial reduces Skin Bacteria



With ordinary soap, the most thorough washing leaves thousands of bacteria on the skin.

With Dial, with Hexachlorophene, daily use removes up to 95% of skin bacteria.

1. *Reduces chance of infection* following abrasions, scratches, for Dial effectively reduces skin bacteria count.

2. *Stops perspiratory odor* by preventing bacterial decomposition of perspiration, known as the chief cause of odor.

3. *Protects infants' skin,* helps prevent impetigo, diaper and heat rash, raw buttocks; stops nursery odor of diapers.

4. *Helps skin disorders* by destroying bacteria that often spread and aggravate pimples, surface blemishes.

You are no doubt familiar with the remarkable antiseptic qualities of Hexachlorophene soaps, as documented in recent literature. Dial was the first Hexachlorophene soap offered to the public.

You can safely recommend Dial. Under normal conditions it is non-toxic, non-irritating, non-sensitizing. Economically priced, Dial is widely available to patients everywhere.

Free to doctors!

As the leading producer of such soaps, we offer you a "Summary of Literature on Hexachlorophene Soaps in the Surgical Scrub." Send for your free copy today.

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Curity chromic sutures

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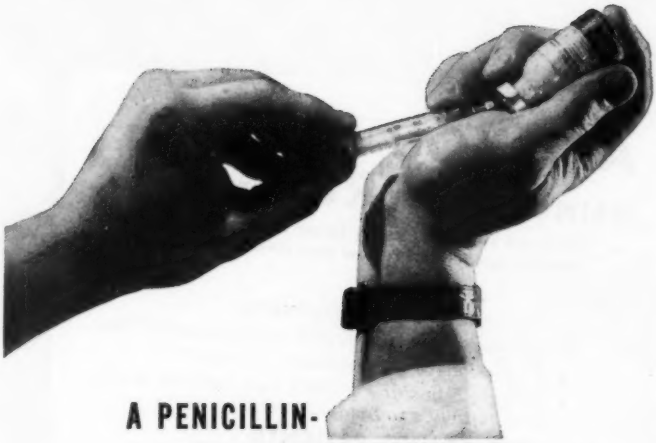
are chromicized with two baths for dependable absorption

Better control of suture absorption rate is now possible with the new Curity method of two-bath chromicizing after the strand has been formed. The first bath *does not "tan"* but permeates the strand. The solution used in the second bath combines with the molecules of the first, within the strand, achieving total, even chromicization from rim to center. As a result absorption is similarly uniform. By this method the plies are bonded by their natural mucin.



A PENICILLIN-DIHYDROSTREPTOMYCIN COMBINATION ready for use AS IS

In Flo-Cillin Aqueous-DS, the broad-spectrum antibacterial combination of penicillin and dihydrostreptomycin are presented... for the first time... in a *permanent, free-flowing aqueous suspension*... ready for instant use without the addition of a diluent or other bothersome preparation.

Flo-Cillin® Aqueous-DS

SUPPLIED IN TWO STRENGTHS:

1. 400,000 units crystalline procaine penicillin G, with 0.5 Gm. dihydrostreptomycin per 2 cc. (dose).
2. 400,000 units crystalline procaine penicillin G, with 1.0 Gm. dihydrostreptomycin per 2 cc. (dose).

AND TWO SIZES:

1. Single-dose vials (2 cc.)
2. Five-dose vials (10 cc.)

SILICONE TREATED "DRAIN-AWAY" VIALS ASSURE FULL DOSAGE.

Bristol
LABORATORIES INC.

IN weight reduction

Biphetacel

*"A combination of monobasic amphetamine phosphate containing a ratio of 1:3 of levo to dextro amphetamine (as found in Biphetacel), is more effective in curbing appetite and causing weight loss than the same amount of amphetamine contained in the racemic form where the ratio is 1:1 l/d. There is a relative freedom from side reactions in the patients with the 1:3 l/d combination . . ."**

Biphetacel, because of its unusual anorexic activity and relative freedom from side reactions due to the 1:3 ratio of l/d forms of amphetamine phosphate monobasic, gives maximum suppression in curbing of appetite in both vagotonic or "sluggish" and sympathicotonic or "high strung" patients, stops hunger pains, and helps to prevent constipation which frequently follows restricted caloric intake.

Each Biphetacel tablet contains the preferred 1:3 l/d ratio as provided by Racemic Amphetamine Phosphate Monobasic 5 mg. and Dextro Amphetamine Phosphate Monobasic 5 mg.; Metropine® (methyl atropine nitrate, Strasenburgh) 1 mg., Sodium Carboxymethylcellulose 200 mg.

Dosage: 1 tablet ½ hour before meals, three times daily, for the vagotonic type. Increase this dose, if necessary, to achieve the desired clinical result. ½ tablet ½ hour before meals, three times daily, for one week for the sympathicotonic type. If no signs of intolerance develop, increase this to 1 tablet. Supplied in bottles of 100 and 1000 scored tablets.

Literature and supply for initiating treatment available on request.

**Freed, S. C. and Mixel, M.—in press*

Effectively Achieves

4 MAJOR OBJECTIVES...

1. CURBS APPETITE
2. PREVENTS CONSTIPATION
3. DECREASES GASTRIC MOTILITY
4. PROLONGS EMPTYING TIME OF STOMACH

Strasenburgh

R. J. STRASENBURGH CO.
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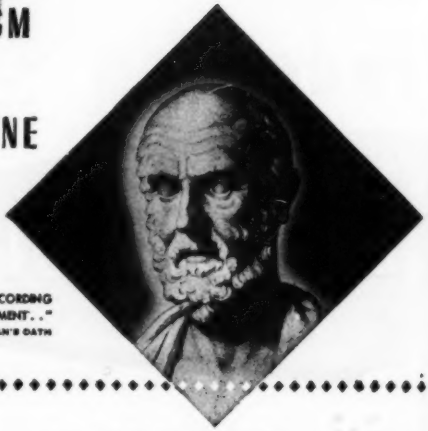

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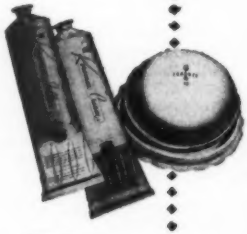

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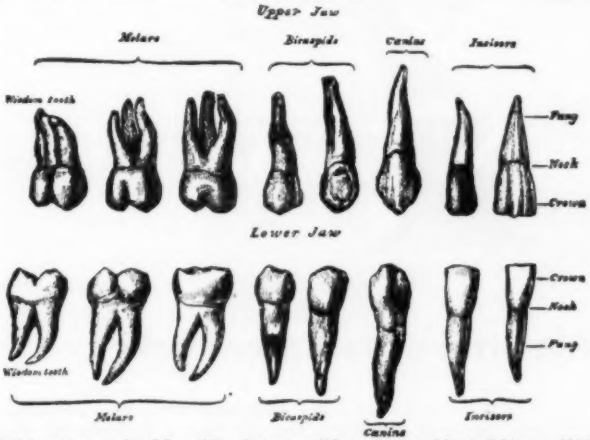

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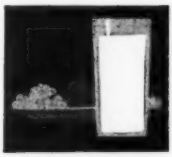

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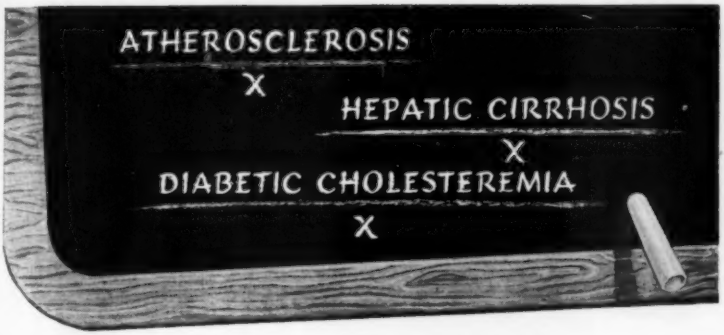

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1. Weidlein, E. R., Jr.: The Biochemistry of Inositol, Bibliographic Series Bulletin, no. 6, Pittsburgh, Pa., Mellon Institute, 1951. 2. Editorial, J. A. M. A. 141:392, 1949. 3. Gertler, M. M., et al.: Circulation 2:517, 1950.

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Editorial

Medical Guarantee

• It's by all odds the most damaging charge that can be leveled against our profession. Yet you hear it every day:

"Because they can't pay for it, hundreds of people around here have to go without needed medical care."

Loose talk? Unfounded rumor? Maybe it is. But doctors will never silence the charge until they *prove* it's untrue.

There's an effective way to do this—so effective that we're surprised more medical communities haven't adopted it. The idea was developed in Alameda County, Calif., and has since caught on in a dozen other areas. Here's its gist:

You enlist the cooperation of your community's free-care agencies. You establish a central office for screening free-care requests. You sign up enough local colleagues to handle night calls, emergency calls, and reduced-rate cases. Then you advertise:

"THE PHYSICIANS OF THIS COUNTY UNCONDITIONALLY GUARANTEE MEDICAL CARE TO EVERYONE . . . Regardless of inability to pay, regardless of the day or time of night, regardless of any consideration or condition, you need only ask to receive the services of a doctor . . ."

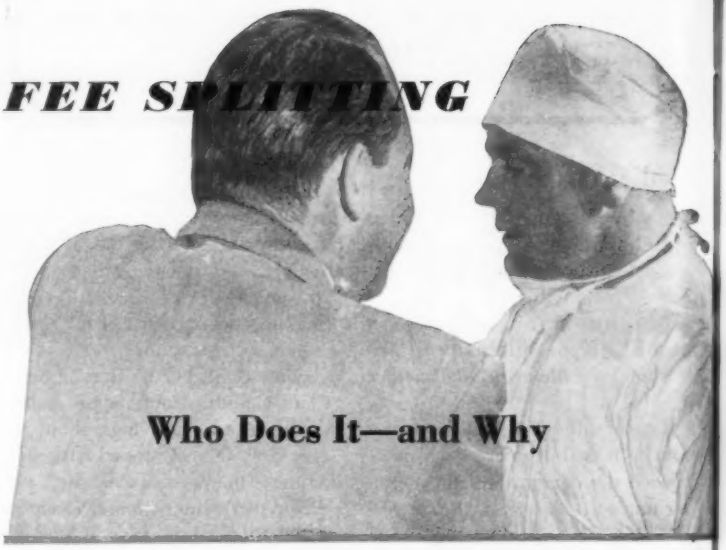
This public pledge, in our opinion, is the best single answer yet devised to medicine's critics. It leaves them with just one comeback: "The doctors can't possibly live up to it." But the doctors, with proper preparation, *can*—and do.

Quite typical is the story of Santa Clara County, Calif. Some doctors there voiced misgivings about the idea ("we'll be swamped with more requests than we can handle," predicted one). But the medical society voted the plan in anyway and got set to handle a thousand ad-answerers a year. Actual volume: about one-sixth of that—less than one patient per member per year.

This guarantee has been tested in both town and country areas, for as long as five years. The groundwork, of course, has had to be carefully laid. The plan may not prove feasible where medical men aren't well enough organized; or where facilities for indigent care don't exist. But even these communities can work up to it. And all others can start now.

Not only can, but should. For the plan (1) proves how few people are able to claim medical neglect; and then (2) helps provide care for those few. —H. S. BAKETEL, M.D.

FEE SPLITTING



Who Does It—and Why

If you want all the facts without frills, read this

● Fee splitting is like adultery: Everyone figures there's a good deal of it going on, but no one knows how much. Chances are that of the two, fee splitting is far and away the more frequent.

Adultery is expensive and entails the constant threat of being caught. But fee splitting is profitable to both parties and is difficult, if not impossible, to detect.

A well-known Chicago gynecologist once estimated that 75 per cent of the city's surgeons were splitting fees. The incidence, he said, ranged from 100 per cent in some sections of the city to zero in others—the latter section including, of course, his own hospital.

** Here's the first of a series on an explosive subject that has too long been kept under wraps. The next article of the series will deal with the ethical and legal implications of fee splitting. Later articles will discuss, among other things, the various programs undertaken to combat it.*

By Robert M. Cunningham Jr.

Whether or not the gynecologist's mean was accurate, there is evidence that both extremes exist—not only in Chicago but elsewhere. According to independent and informed sources of two types—inspectors for the American College of Surgeons and agents of the Bureau of Internal Revenue—there are some towns in which fee splitting is rampant and others in which it is apparently nonexistent.

Dr. Paul R. Hawley, whose position as director of the college makes him the fee splitter's hair shirt, has remarked on the spotty geographic distribution of fee splitting. "There are certain parts of the country in which it is very prevalent—in the Middle West, Illinois, Indiana, and Iowa," Dr. Hawley told a group of physicians not long ago; "yet I am assured by men whose veracity I wouldn't question that it just doesn't exist in Virginia. On the other hand, a distinguished surgeon told me there is one little spot up in his territory where no one could make a living *unless* he divided fees."

Marx held that man is essentially an economic creature; and certainly there is economic motivation for the fee splits that occur in medicine today. As a rule, fee splitting is most prevalent in one- or two-hospital towns of medium size (25,000 to 100,000) and in the outlying neighborhoods and smaller hospitals of big cities. It is least prevalent among the members of medical-center teaching staffs.

The reasons are the same at both ends: Fee splitting follows the curve of financial competition in medical practice. In the medium-sized town where, say, half a dozen surgeons vie for the referrals of a couple of dozen practitioners, competition is fierce; in this situation, fee splitting is likely to occur.

It begins as the refuge of the professionally weak or insecure surgeon. Then, in a medical application of Gresham's famous economic pronouncement that "bad" money drives out "good," bad practice drives out good practice. The surgeon who is competent and has always been honest finds his practice dwindling unless he meets the fee splitter on his own ground. Eventually, everybody's doing it.

Temptation for Youth

The economic pressure that results in fee splitting is especially severe in the case of the young surgeon who is just getting started in practice—and, simultaneously, in family life. "The temptation is greater among younger doctors than among older ones," Dr. John W. Sherrick of Oakland, Calif., has pointed out in an article in the Bulletin of the Alameda County Medical Association. The obvious reason for this, he says, is that the younger men are likely to be "burdened down with debt incurred in their long period of training, and are seeking to establish a practice."

Fee splitting is also more preva-

lent among the poor than the well-to-do, according to Sherrick. And it thrives better "among the less competent, outside of medical schools and their teaching hospitals than in them, and in certain sections of the country."

Under whatever circumstances it occurs, though, the object of the fee splitter's defection is always the same—money. "I've certainly had my eyes opened here," a hospital administrator in one Midwestern community said recently. "I was in the hotel business for a number of years before I came to this hospital five years ago, and I had the idealistic view that doctors were different. But I guess I was wrong. Like everybody else, the doctors here are after a fast buck."

This is by no means universally true. In some underdoctored rural areas, for example, overworked practitioners may often wish they could pay a colleague *to take patients off their hands;* they never even think of being *paid* for referrals.

In communities like these, moreover, professional as well as economic conditions are less conducive to fee splitting. Complicated surgical cases are likely to disappear up the road to the big city, propelled by fear or by the honest recommendations of baffled and busy practitioners.

Virtue can also live at the other end of that road. The specialist on a teaching hospital staff may still be in a competitive situation, of course, and he may split fees occasionally. But more often, his patients reflect honest professional referrals from other departments on the same staff.

If such referrals are sometimes stimulated by bridge and golf friendships and by social connections, Hippocrates himself would probably not bat an eye. For physicians are, after all, human beings; and the give and take of human relationships will be with us always.

The Luxury of Virtue

Teaching staffs may, of course, include a liberal sprinkling of reformed, or graduated, fee splitters. These are men who split fees on the way up, under pressure of economic necessity, but whose competence—or energy, or good fortune, or all three—has now brought them to a position in which fee splitting is unnecessary. For them, virtue is an affordable luxury.

"I split fees for a while, and I hated it!" one surgeon told a friend in a burst of frankness. "But I'm not sure I could have survived if I hadn't."

Not all fee splitters are equally honest with themselves. Some profess to see nothing wrong with the practice; others engage in forms of fee splitting that are disguised or diluted enough to let them persuade themselves that black is actually white. Only in rare cases is there a real question about whether or not a particular practice *is* fee splitting.

A professional relations commit-

Be Wise: Itemize

tee of the American College of Surgeons, headed by Dr. Warren H. Cole of Chicago, has listed five forms of fee splitting. Here, substantially, is the way they're described:

Its Five Faces

1. The surgeon collects a fee and remits part of it to the referring physician.

2. The surgeon operates and is paid for his service by the referring physician, who collects the bill. On some such occasions the patient remains unaware of the role of the surgeon; this is "ghost surgery," or poor man's fee splitting.

3. The referring physician acts as an assistant at the operation, gives the anesthetic, or performs some function in post-operative care. For these services he receives payment from the surgeon.

(This is tricky business, by the way. For when qualified assistants and anesthetists are available and the referring physician still acts in one of these capacities, it is plainly a subterfuge for fee splitting. Says the committee: "Such a subterfuge is not necessary to justify adequate remuneration of the referring physician for his medical services to the patient." When, in the absence of qualified assistants or anesthetists, the referring physician performs these services, he is advised to send his own bill.)

"Backwards, it doesn't spell anything. But let's try it anyway, shall we?"

4. A clinic or group of physicians pays a salary to another physician (often in a near-by community or outlying district) as compensation for referring patients.

5. The physician refers a patient to a pharmacist, optical company, brace shop, or other supplier, and accepts a rebate or commission on the charge made by such supplier to the patient for material purchased.

Almost Fee Splitting

Things not necessarily unethical in themselves but frowned on by the Cole committee as borderline or likely to contribute to delinquency are:

(a) The combined bill sent by a physician to cover his own and another physician's services. This is considered bad because it may be a screen for fee splitting. Combined bills are not questionable, though, when sent by bona fide clinics (whose members are on a salary or partnership arrangement) or by hospitals whose staffs have authorized the sending of itemized bills for professional services.

(b) Combined bills sent to an insurance company for the services of two or more physicians to an insured patient. When insurance companies insist on such combined bills, the college urges doctors to make certain that the bills are itemized and that payment is made separately to each physician.

Some general practitioners who wouldn't accept a direct split or rebate will routinely "assist" at operations, then send combined bills—and indignantly deny wrongdoing. One such G.P. who practices in a "fee-splitting area" and is secretary of his county medical society waxed bitter about this at a recent meeting.

Just 'Group Practice'?

"A private medical group," he said, "can send a blanket bill to a patient and never be questioned. But just let two or more doctors who practice independently try this! For them, there's but one acceptable policy, fair or not, and that's to render separate bills.

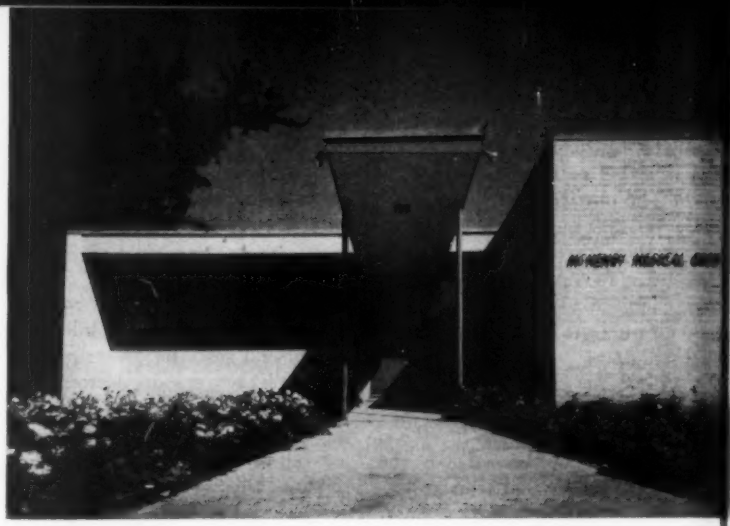
"Yet compare the role played by the surgeon with that played by the general practitioner in a typical case:

"When nurses, anesthetists, and residents have everything in readiness—and not until then—the surgeon walks in, makes the incision, removes or repairs the offending organ, sews the patient up, takes a shower, and times his entry into the patient's room so that the family will be present to hear the encouraging prognosis.

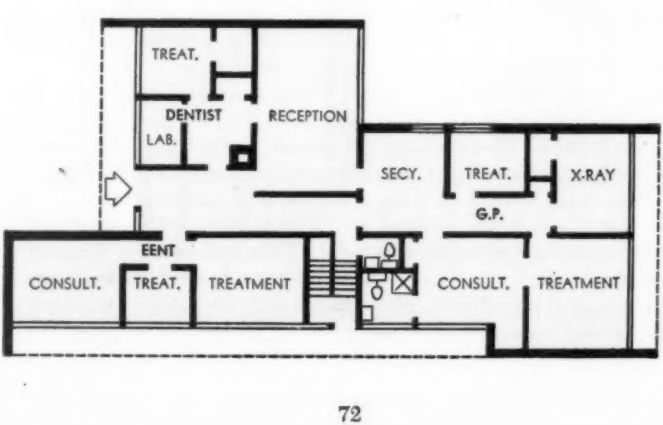
"After a week of daily visits, the patient is well, the sutures are taken out, and he goes home. The surgeon has worked a total of four hours, including post-operative care.

"The family doctor, meanwhile, did all the pre-operative diagnostic work; he made most of the arrangements with the patient for surgery;

[*Continued on page* 184]



Small-Town Office Goes Modern



ARCHITECT: JOHN VAN DER MEULEN

• Many a rural doctor likes modern architecture but shies away from it when building a medical office. Too extreme, he fears, for small-town tastes. Not so, Lee Gladstone.

His $35,000 flat-topped building, pictured here, caused a stir at first among the 1,600 residents of McHenry, Ill. But they got used to it; and all three of the building's occupants—Gladstone, an EENT specialist, and a dentist—now report flourishing practices.

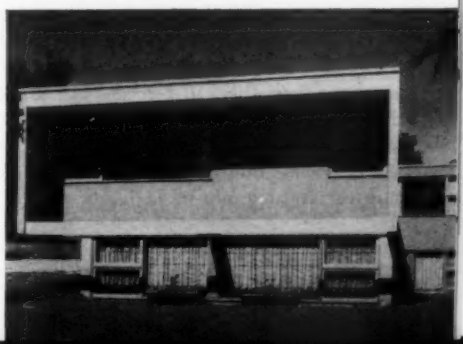
Some features worth noting:

The long, wooden canopy at the entrance is practical as well as ornamental. In bad weather, it can shelter several patients awaiting rides.

Contrast is provided in the exterior by combining brick with vertical wood siding. The overhanging roof shades rooms from high summer sun but lets in low winter sun.

Because of the slope of the land, there are two floors in the rear of the building. The lower floor houses a lab, a utility room, and a four-room apartment that could easily be converted into additional office space.

The building also serves as a part-time office for six specialists from Chicago (55 miles away), who visit it once or twice a week. END



Anti-Vivisectionists on the Run

Medical men deal them a crushing defeat in one of their old strongholds

• In their long and bitter struggle against the anti-vivisectionists, doctors and research scientists have often been bested. Last year, for instance, the dog cultists defeated six out of ten state bills to aid animal research.

Today, twenty-six states still do not legally recognize animal experimentation. Three others (Maine, Massachusetts, Pennsylvania) limit biological research by law. In most parts of the country, laws prevent the requisitioning of dogs for experiments that in the past have resulted in such discoveries as anesthesia, insulin, and ACTH. While researchers tear their hair for canine subjects, thousands of unwanted dogs are killed in pounds every day at public expense.

The exasperating fact, to the average M.D., is that a very small minority is responsible for these restrictions. Less than 10 per cent of the people actually oppose animal experimentation, according to one recent survey. But the power of this tiny yet vocal group of high-powered promoters, wealthy old ladies, assorted cultists, and impassioned crackpots is far out of proportion to its size.

The tide has begun to turn, though. Six years back, medical men and research scientists set up the National Society for Medical Research. Under the leadership of Drs. A. J. Carlson and A. C. Ivy, the society has helped local doctors throughout the country in their battles with anti-vivisectionists.

As a result, twenty-three cities and five states (Minnesota, South Dakota, Oklahoma, Wisconsin, New York) have passed laws permitting researchers to requisition unclaimed pound animals for scientific experiments. Last to join the fold was New York. It was also the hardest nut to crack; but victory, when it came last month, was sweet.

The state had long been a stronghold of anti-vivisectionist forces. As late as 1945, they almost got a bill passed to prohibit animal experimentation altogether. In 1950 and 1951, they successfully bottled up legislation to allow researchers the use of unwanted pound dogs. They seemed likely to repeat their success in 1952.

By Roger Menges

But New York medical men launched a full-scale campaign to get the bill passed. A bitter fight resulted; and in the midst of it, many a doctor must have wondered whether the campaign might not boomerang.

Unveiled Threats

An avalanche of letters descended on the capitol. The bill's two sponsors, Sen. George R. Metcalf of Auburn and Assemblyman A. Gould Hatch of Rochester, received threatening letters. Said one, signed "Defenders of the Weak": "You will be visited while you are sleeping and you will . . . experience the suffering and brutality that you are attempting to legalize for defenseless dogs."

Harold C. Wiggers, assistant dean of Albany Medical College, also got a threatening letter, warning him to stop supporting the bill. Remembering the attempt on the life of a Los Angeles scientist by a youthful anti-vivisectionist, Dean Wiggers promptly turned the letter over to the F.B.I.

Newspaper editors found their mailboxes choked with highly emotional letters. One, received by The New York Daily News from a woman reader, asked: "Why don't they take all the good-for-nothing drunken sots, male and female, and cut them to hell up and leave our faithful, trustworthy dogs alone?"

A prominent human society director seriously suggested to two medical students that the doctors "carve up" bums and minority groups rather than dogs and cats. Other opposition spokesmen had equally heart-warming ideas. Mrs. William T. Schneider Jr., for instance. Mrs. Schneider is the managing director of the Long Island Anti-Vivisection League, and she believes that animal experimentation is simply a plot "to get money from the government to put doctors to work."

Or take Evelyn Siyufy, secretary and director of the Long Island Humane and Dog Protective Association. Scientists, she pointed out, "have found out very little—nothing, in fact—from experiments on animals. Some doctors are sadistic. They get a kick out of cutting up or torturing dogs."

Children Are Next

Even charges of totalitarianism entered the campaign. One dog cultist, for example, warned that it was "only a step from the confiscation of pets to the snatching of children from foundling homes or dragging people from their beds at the demand of the state."

Weird as such arguments were, the doctors knew better than to underestimate the opposition. Early last fall they formed an organization to run their campaign—the New York State Society for Medical Research. (Anti-vivisectionists promptly renamed it the New York State Society for Medical Butchers.) Frederick S. Philips, associate of the Sloan-Kettering Institute for Cancer

Research, was appointed its head.

To set up the campaign machinery and keep it running smoothly, the society imported Phillip S. Gelb, a public relations man and a veteran of similar campaigns in Minnesota and Los Angeles.

Gelb's first action was to make a state-wide survey of medical scientists and teachers, to determine the adequacy of existing facilities for research. What he found made good factual publicity: 133 projects had been hampered, delayed, or abandoned during the year because of a shortage of experimental dogs and cats.

All in all, about 25,000 of these animals would have filled the researchers' needs, according to reliable estimates. Yet 450,000 unwanted dogs and cats were being destroyed yearly in New York's pounds.

Doctors in Action

Though the state research society supplied much of the ammunition for the battle, local medical men were its shock troops. Throughout the state, they whipped up support for the bill. New York doctors enlisted the help of Manhattan socialite Mrs. E. C. Delafield, who got key people and organizations (about 250) to back the bill. Doctors like W. C. Hausheer of Staten Island addressed and won over local Kiwanis and other groups. Dr. Cornelius P. Rhoads, director of the New York City Memorial Cancer Center, stumped the state.

M.D.'s and Ph.D.'s called on the editors of their local newspapers and generated editorial support. In the end, only a handful of publications were openly opposed to the bill. (Notably silent was the Hearst press, which for decades had spearheaded almost every crusade against animal experimentation. Apparently W. R.'s death had changed or modified its editorial stand.)

In Brooklyn, doctors' wives visited every hospital in the borough, urging the staffs and patients to write their legislators. Medical men throughout the state trekked to Albany for personal talks with the lawmakers. And these efforts paid off.

In Kings County, for instance, doctors and their wives, together with the medical society's legislative committee (headed by Dr. Aaron Kottler), won over all nine of their senators and twenty of their twenty-four assemblymen.

In another county, all assemblymen were reportedly against the measure. Doctors visited county political leaders and convinced them of the rightness of medicine's stand. As a result, the assemblymen reversed their position.

On February 14, the legislature held a public hearing in Albany. Twenty-nine people presented their views amid heavy applause and loud catcalls from a raucous gallery. Physicians and scientists mostly ticked off examples of how animal experiments had paid off in medical dis-

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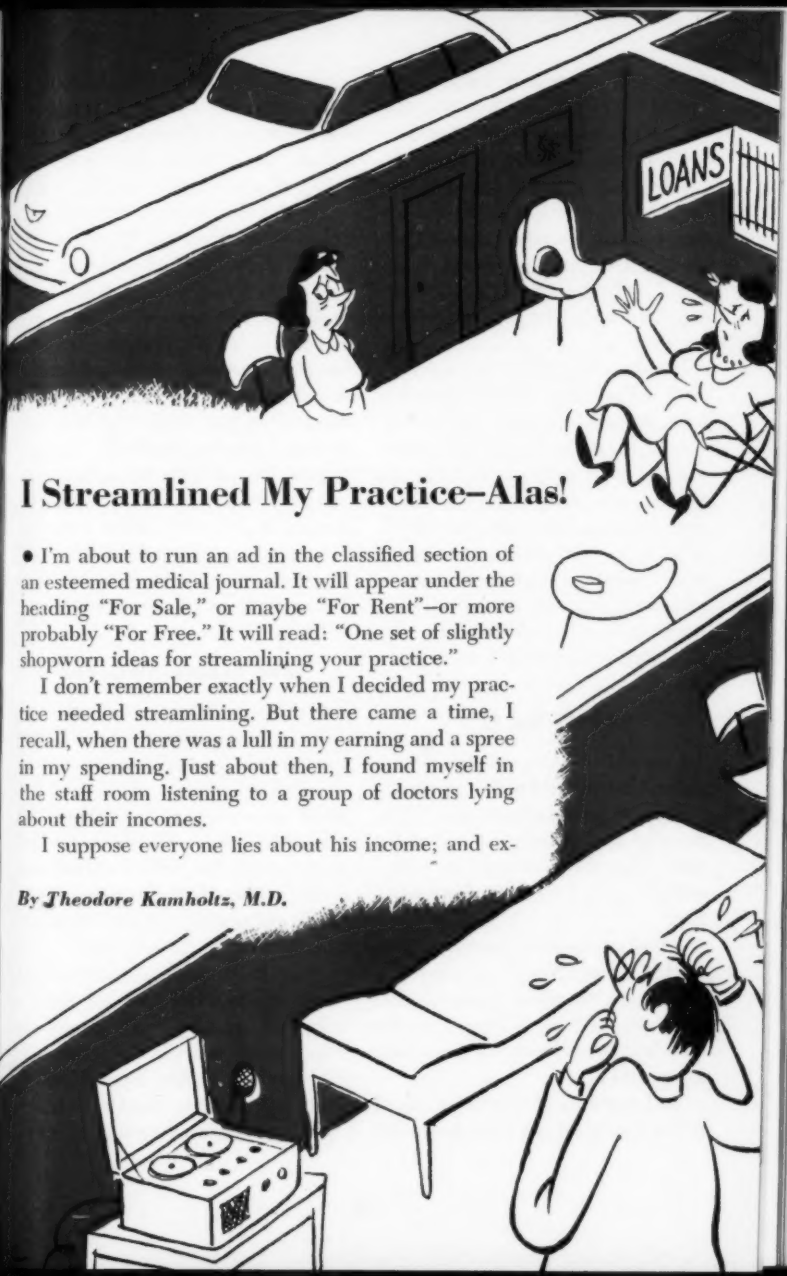


I Streamlined My Practice–Alas!

• I'm about to run an ad in the classified section of an esteemed medical journal. It will appear under the heading "For Sale," or maybe "For Rent"—or more probably "For Free." It will read: "One set of slightly shopworn ideas for streamlining your practice."

I don't remember exactly when I decided my practice needed streamlining. But there came a time, I recall, when there was a lull in my earning and a spree in my spending. Just about then, I found myself in the staff room listening to a group of doctors lying about their incomes.

I suppose everyone lies about his income; and ex-

By Theodore Kamholtz, M.D.

cept for the divisional influence of the Bureau of Internal Revenue, the tendency is multiplicative. Anyway, there I was, listening to everyone pad his treasury—and by some delusion believing it. It was like a group of fishermen discussing their catches. I sat humble, round-shouldered, and plunged in gloom, thinking of the ones that got away—from me, that is.

It just so happened that my wife went to the ladies' auxiliary meeting a day or two later. Her spiked version of the proceedings had everyone and his wife sailing to Bermuda on his own yacht, with silver-blue mink bathing suits and cantaloupe-sized diamond rings the order of the day. The husbands of those women, said my wife, were so bushed from stacking hundred-dollar bills that they simply had to get away for a rest.

Why Not I?

Crushed, I accepted the thinly-veiled hint and retired to my study to think. What was the trouble? Why wasn't *I* as agreeably bushed as the rest? Was there something wrong with the way I conducted my practice?

I had never paid much attention to this before. Now I realized that there were *too many* things I hadn't paid attention to. I knew that the time had come for me to make over my practice.

So I started with my car. I turned in the sturdy old one for a chartreuse convertible Cadillac—the kind you can make a U-turn with only if you're on an airfield. This, I reasoned, would give my practice a touch of much-needed dash.

All the next week, patients kept asking me whether they really *needed* the prescribed injection, operation, or return visit—or was it just to pay for The Lemon (as we came to call the car)? Then I got calls from three women, all named Smith, who wanted to know if I did abortions. Was this really the kind of dash my practice needed?

Mrs. Mogul came to me because, as she put it, anyone who could drive a chartreuse Cadillac *must* be able to take out her gall bladder and treat Sweets' cold. That sounds confusing until you know that Sweets is her pet Pekingese.

The Lemon Squeezed

So things worked out about fifty-fifty, with my public relations better uptown and poorer downtown as a result of my new car. Then a trailer truck came along and clambered all over the Lemon while it was parked at the curb. My wife consoled me with the fact that chartreuse never really *did* anything for her complexion anyway.

With the insurance money, I got a car one squeak removed from a jalopy. This soon had a disastrous effect on my practice. Sweets couldn't stand the rattle. Even patients in the public clinic asked to be transferred to some other doctor, since

I obviously was a failure in private practice.

So I engineered a trade-in. Today I own a middle-priced car that no one at all notices except the traffic cop.

A Suite for Sweets

About this time, my office came up for re-examination. I had always considered it just right. It was serviceable, efficient, and rather neat. There was a place for everything, including an ash tray under the sofa for people who like to crush out their cigarettes there. But you couldn't call it streamlined.

So I summoned an architect, an interior decorator, an efficiency expert, and the finance company. The next thing I knew, I had a fourteen-room suite.

There was an intercom arrangement with buzzers—one for the receptionist, two for the nurse, three for the secretary. There was also a red light for stop and a green for go.

Soft music played in the waiting room. Movies flashed on the ceiling of the examining room for patients to watch while undergoing pelvic examinations. There were modern contour chairs, with printed directions telling how to sit down in them. The whole effect was restful, dignified, and beautiful—something like the men's room in a fancy movie house.

But soon I began to have trouble. I had bought the newest therapeutic and diagnostic equipment, since it had been proved to me in black and white that such things pay for themselves in the first forty-eight hours. But no one had ever told me what it costs when an X-ray tube blows.

What's more, people seemed to resent having their basal metabolism rate tested more than twice a day. So I gradually unloaded my excess professional equipment, except for the electroencephalograph. There's a bird's nest in that, and I'm waiting for the eggs to hatch.

The other office improvements disintegrated slowly. Somebody switched the soft music to racing results, and I felt in imminent danger of being raided. Then my nurse complained that the intercom buzzer kept her awake, so we stopped using the thing. Finally, we had to replace the contour chairs. This decision was reached when a woman with short legs and broad beam proved unable to extricate herself from a canvas sling model.

No More Latin

My most intense streamlining efforts centered around the doctor-patient relationship. I planned to use no word of over one syllable. No more abracadabra, no Latin, no technical terms. The effect on my practice was immediate: Office hours soon lasted five times as long, with only half the number of patients.

This was my period of utter honesty and frankness with patients. My

[*Continued on page* 163]

Doctors Take to TV

What's it like to be featured on the nation's television screens? A report on the biggest health program to date

● Into the National Broadcasting Company's arena-like Studio 8H, not long ago, walked a trio of performers who, it was a safe guess, hadn't been sent by Central Casting.

The three men were physicians, venturing into a jungle of klieg lights and mechanical booms for their debuts before a coast-to-coast television audience. Their vehicle: the new physician-sponsored program, "Here's to Your Health," which shapes up as possibly the most ambitious health education project ever undertaken by the medical profession.

For the visiting M.D.'s, one of whom had come 1,200 miles to New York for his half-hour stint before the cameras, this was no lark. Working with the New York County medical society (which had developed

By James G. Blake

What might have seemed a meeting of strange bedfellows—the doctor and the TV camera—proved a happy marriage of talents during the second coast-to-coast telecast of "Here's to Your Health." The subtitle of this episode: "Hope for You and Your Heart." Getting orientation from N.B.C. producer Craig Allen, next to camera, are (left to right) Dr. Lester L. Coleman, supervisor of the health program; Dr. Arlie Barnes of the Mayo Clinic; Dr. Scott Butterworth of New York University; Dr. Howard Sprague of Massachusetts General Hospital. After this briefing, the visiting heart specialists settled down to a stiff dose of rehearsals.

Above, a TV assistant relays a message to the doctors from the program director, who is watching the rehearsals on a monitor screen offstage. Sitting at Dr. Barnes' left is Jack McCoy, a professional announcer, who moderated the physicians' show. Brief discussion periods, like the one shown in action at right, are interspersed between the clinical demonstrations.

Doctors Take to TV *(Cont.)*

During rehearsal, Dr. Sprague makes suggestion about his ECG demonstrati

A director chalks guidelines on the floor so that Drs. Butterworth and Sprague will know their places during their dual act. Sequence begins (at left, below) with Dr. Sprague's explanation of the arterial-venous system, and ends (right, below) with Dr. Butterworth's examination of a steamfitter with a heart murmur. TV audience could hear the man's heart beat.

TURN PAGE

The dress rehearsal over, Dr. Butterworth is first to occupy the make-up chair. As air time draws near, he brushes up on his lines once more.

Doctors Take To TV *(Cont.)*

After a brief dramatic skit played by professional actors—this one is about a middle-aged heart patient—the camera begins

to pan in on the panel of doctors, who sit by tensely. At the far right, Moderator McCoy joins the trio—and the doctors are on the air!

TURN PAGE

Doctors Take To TV *(Cont.)*

Dr. Sprague interviews a woman who underwent a commissuratomy. Children at left were once "blue babies."

Moderator McCoy, behind the fluoroscope, grins broadly as Arlie Barnes quips: "You'd better see a doctor." Fluoroscopy scene, as the camera recorded it, appears at left. Though the doctors have memorized their lines, they can pick up cues from prompt boards like the one above.

At program's end, Dr. Kenneth Lewis speaks for the New York county society. Medical societies in other areas have been invited to take an active part in the program at this interval.

"Here's to Your Health" winds up with cameras focused on the county medical society seal. Dour propman, not seen by home television viewers, seems unimpressed by the whole affair.➤

this experiment in TV medicine), the three physician-performers set about a considerable task: that of presenting authentic medical facts in a manner lively enough to compete with TV's song-and-dance fare.

This meant that lines had to be pat; movements natural but precise, and synchronized. Patiently, the medical men went through their paces many times during rehearsals.

Nearly six hours after they had entered this strange electronic world, the doctors went into a mirrored room next to the studio and had their faces smeared with orange-brown pancake make-up. Then they went back under the bright lights of 8H—this time "for keeps."

This is how doctors themselves have dispensed authoritative medical information, through the coaxial cable, to thousands of Americans in recent weeks. [*Turn page*]

Each edition of "Here's to Your Health" has a new format, a new cast of characters, and treats a new subject. On the inaugural show, the topic was polio, and part of the production took place in the Institute of Physical Medicine and Rehabilitation, New York. There, young victims of crippling disease were shown undergoing treatment and, later, in various stages of recovery.

Subsequent programs, like the first, have featured real doctors making real diagnoses and real patients undergoing real treatment. Perhaps this is why one TV critic says the health program "bears the stamp of integrity."

Five Objectives

All in all, "Here's to Your Health" seems to be fulfilling its five objectives with plenty to spare. These objectives, as stated near the beginning of each program, are:

"1. To acknowledge the public's right to receive authoritative information from medical experts.

"2. To explain and evaluate the newest scientific discoveries in medicine.

"3. To expose false claims and misinterpretation of medical facts.

"4. To create a greater bond of understanding between the patient and the doctor.

"5. To replace anxiety and fear with encouragement and hope."

Just how many thousands of listeners are attracted by this health show is not known for certain. But this much is known: A "live" telecast of one recent "Here's to Your Health" program was seen in nine cities across the nation. In this nine-city area, there are about 5.5 million television sets. Another 4 million TV receivers are in the fourteen cities that later saw a kinescoped (or filmed) version of the program. TV researchers say that a conservative estimate would put the audience for a single show at more than a million.

Critics Rave

Signs are that those who do see the show like what they see. From several TV critics came resounding huzzas after the first program. Witness what these professional viewers wrote about "Here's to Your Health":

Jack Gould, of the New York Times: "Traditionally so reticent in dealing with the public en masse, the medical profession this time is displaying commendable initiative in clearing away the fear and confusion that so often are attached to . . . diseases."

Larry Wolters, of the Chicago Daily Tribune: "When TV does such things it is not only an instrument of education and enlightenment; it is a magic mirror that reflects the faith, the hope, and the courage of the human spirit."

Harriet Van Horne, of the New York World-Telegram and Sun: "As educational programs go, this was notches above average . . . Best

[*Continued on page* 189]

But *IS* It 'Payment in Full'?

Be wary of a check so marked if its amount is less than your billing

• A patient owes you $140. You bill him, but he insists that he has been overcharged. Even when you send him an itemized statement, he continues to protest. Finally, he sends you a check for $100, endorsed "Payment in full." What should you do with that check?

If you're willing to accept the $100 (or whatever the amount may be) as full payment, deposit the check. If you are not, do one of two things: Return the check with a note explaining that the correct balance is $140; or hold it and write the debtor, naming the correct amount and asking him for an acknowledgment of your letter.

If he doesn't answer within ten days, return the check to him immediately. *Do not* keep permanent possession of an undeposited check (being tempted, perhaps, to regard it as evidence of a debt). If you do, a court may rule that you accepted it in full payment even though you didn't deposit it.

There are good, legal reasons for being so wary. Physicians would therefore do well to adhere strictly to a simple rule: Never deposit a check marked with such words as "Payment in full" unless it *is* in full payment—or unless you are willing to accept it as such.

If you do deposit the check, you imperil your legal right to collect the balance. Courts usually sustain the debtor in such cases. According to one ruling, "It is of no significance that the remittance was by check. Both parties treated it as money, and upon [its] receipt the plaintiff had but a single alternative . . . the prompt restoration of the money to the debtor or the complete extinguishment of the debt by its retention."

In other words, you can't accept the check and reject the condition. You must accept or reject both. Nor can you protect yourself by scratching out the words "Payment in full."

Note, though, that this rule applies only when a bill has been disputed. If a patient specifically agrees to pay you $500, then sends a check for $100 marked "Payment in full,"

By Wanda Young, LL.B.
**In the course of her work as a Los Angeles attorney, Miss Young devotes special attention to medico-legal work.*

you may be able to deposit it without forfeiting your right to collect the balance.

This distinction has inspired more than one debtor to dispute bills and send out inadequate checks marked "Payment in full" in the hope that some of them would get by. If the creditor endorses such a check, he has accepted the debtor's appraisal of it, no matter what the books may show.

Beware, too, of what is sometimes called the "belated endorsement." The tricky debtor sends out a check in partial payment, and the creditor endorses it and deposits it. Later, when the debtor gets the canceled check from his bank, he writes "Payment in full" above the endorsement. If litigation follows, he says he wrote the phrase when he drew up the check. Then it's only one man's word against another's—unless your bank microfilms all its checks.

Avoid such a situation by making it a practice to sign your endorsement so close to the top of the check that nothing can be written or typed above it. END

An Emergency Is an Emergency Is an Emergency

A three-week-old corn
That aches in the wee hours of the morn,
Or a leg that is painful
When it is rainful,
Or a lifelong tendency to regurgency—
None of those ailments has urgency.
Not cheerfully, but at least dutifully, I will arise in the dead of night to sew up a cut.
But—
Mayhem
At three Ayhem
Is one thing; while getting my poor aching wreck up
To do a general check-up
Is quite another.
So, brother,
Don't ring my phone at three in the morning to complain of frequency, burning, and discharge; and don't call it "urgency."
For an emergency is an emergency is an emergency.

—JOHN L. MEYER II, M.D.

Hermann Sander–Two Years Later

Air-bubble M.D. still lacks hospital and society status, but hopes for early relief

• Manchester, N.H., was wrapped in snow when I visited it this winter, just as it had been two years before when Dr. Hermann N. Sander was standing trial there for his life. Of course things were quieter this time. But you could sense that few people had forgotten the syringe-death case that for weeks in 1950 had focused national attention on the town, its medical men, and the underlying medical-moral issue that had been so carefully avoided in the courtroom.

It was early morning when I arrived, and I dropped into a drug store for coffee. "How's Dr. Sander making out these days?" I asked the counterman.

"Whyn't you ask him?" The shrewd New England eyes looked me over coolly. "He's a fine man; that's all I got to say."

I took my time with the coffee, glancing once more through the old newspaper clippings I'd brought along. The doctor had been arrested on December 29, 1949, charged with the killing on December 4 of a 59-year-old female cancer patient in a dying condition at Hillsborough County General Hospital. His own dictated record of the case, filed December 12 at the hospital, showed that he had injected forty cubic centimeters of air into a vein; death was recorded as occurring ten minutes afterward.

At the three-week trial in February and March, he said that the record was wrong, that the woman was already dead when he made the injection, and that his mind had "snapped." His seven-man legal staff argued that there was reasonable doubt she had been living, or that he had really reached a vein, or that he had injected a lethal dose, or that the vein had been open to the heart, or that an embolus had been formed, or that air embolism had been the cause of death. The jury took only seventy minutes to vote the doctor's acquittal.

Shortly afterward, the House of Delegates of the New Hampshire Medical Society met for four hours behind closed doors, then issued a statement disavowing euthanasia, pointing out that physicians were "human beings subject to human errors of judgment," and deferring to

By J. Alvin Kugelmass

During the time that his medical license was suspended, Hermann Sander did considerable fence-mending—both literally and among his colleagues.

the Hillsborough County society on disciplinary action.

The county society promptly expelled Sander. So did all three of Manchester's voluntary hospitals (two of them, Catholic institutions, barring him for life). The state revoked his license, but restored it two months later.

Thus matters still stood on the occasion of my visit. The doctor, understandably, had been none too encouraging when I called him long distance the day before. "I'm not news any more," he'd said. "Don't think I'm rude, but I'd rather not see you."

I mentioned that some of his colleagues were going to be interviewed, but he again demurred. "I'd prefer to forget the whole thing," he said.

"Can you?" I asked.

He chuckled, and said he might if fellows like me would let him.

Finally he relented. "Well, all right, if you're coming up anyhow," he said, a shrug in his voice. "But I hope you get stuck in the snow and catch cold."

He was tied up till afternoon, so I used the morning for my other calls. None of the physicians I talked with wanted to be quoted by name, again understandably. All had been close to the case; some still were. Here's the gist of what they told me:

¶ Hermann Sander is personally well liked, both in the profession and out. His concern with medicine's sociological aspects, his possible leaning toward something other than the present scheme of private medical practice, have had no bearing on the handling of his case.

¶ He was voted out of the local society by a three-fourths majority. He needs a two-thirds majority to get back in, and will probably make it at this year's May meeting. He missed only narrowly last time, in November, 1951.

¶ Getting reappointed to the only local hospital staff open to him will be something else again—even assuming a thumbs-up from the society. Acceptance by the hospital will depend on the vote of its thirty-man

staff. And only four nays can keep him out.

Some of Sander's tribulations might never have come to pass had it not been for the convictions of certain Hillsborough County physicians who felt that, in the best interests of the profession, Sander should not go scot free. When the delegates to the state medical society first met on the case, they were inclined to find no cause for disciplinary action against Sander. Had they announced this stand, it would presumably have ended the matter for the local society and at least for one of the hospitals (non-Catholic) that later booted him out. But they had failed to reckon with the persuasive oratory of the members of the Hillsborough County delegation, who felt that Sander should not escape penalty.

"They wanted to whitewash Sander," these delegates told me; "just because of the lay jury acquittal. We fought them for four solid hours, with the press waiting for a statement.

"Our point was that if we whitewashed the man, we'd be seeming to condone euthanasia. We'd be giving younger men in medicine the idea that they could get away with it too. We'd be telling everybody that we considered ourselves qualified to play God. Imagine how that would have undermined public confidence!"

One of the delegates described the "hypodermic hysteria" that had gripped the county at the time. "People recoiled from the needle. Sometimes they refused hypo medication point blank." He paused, smiling a little, as though it were all pretty hard to believe now. Finally he said: "Well, that was a couple of years ago, of course, and Hermann's taken his beating. I think he's learned. I hope he's voted back in at our next society meeting."

These sentiments were echoed by others I talked with. One was the man to whom Dr. Sander has been referring all his obstetrical and gynecological work, formerly his special interest. "If for no other reason than to exercise better guidance and control of such men," said this M.D., "the society should take Sander back."

Meet Dr. Sander

My chat with Dr. Sander himself took place at his office on Elm Street, Manchester's main thoroughfare. He was on the third floor of a gray and elderly office building housing a miscellany of business and professional establishments, mostly lawyers and other doctors. He hadn't yet arrived when I got there, but his secretary said he'd be along soon.

Ensconced in a black leather sofa, I looked over his wall display of credentials. He was graduated in 1938 from New York University College of Medicine and spent a two-year residency at the Mountainside Hospital, Montclair, N.J. His license had been issued in 1941.

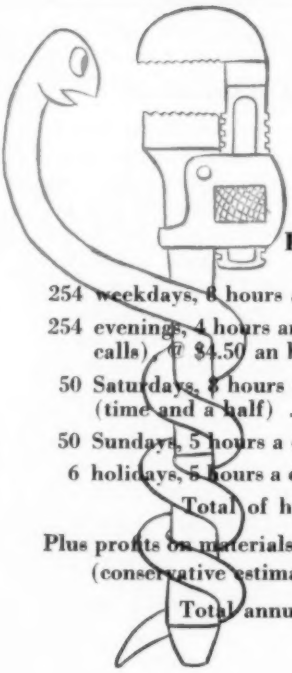
A few patients arrived, took off

their overcoats and overshoes, and sat down to wait. Snow melted in small puddles on the floor under the clothes tree. Presently there was a stamping outside the door, and Dr. Sander bustled in with his bag. He greeted his patients by their first names, gave me a smile and a handshake, and went into his consultation room. His secretary followed, bearing his mail, and a moment later reappeared to ask me in.

Sander looked older than his news photos, and, of course, he was—being now 43. The news pictures portrayed him as lean-faced, with a kind of British military mustache. But he had put on weight since "the thing," as he called it, took place; so his mustache, a glossy black, appeared smaller. He was wearing a double-breasted blue suit and an electric-blue tie with Daliesque figures on it.

"What can I tell you?" he asked, after I had been seated.

Before I could reply, his phone rang and he was assuring a hectic-voiced mother that he would be by to see her offspring later that afternoon. "Just keep him in bed and give him plenty of juices and toys," he



If Docto

Physician's Hours, Plumber's Pay

254 weekdays, 8 hours a day, @ $3 an hour	$ 6,096
254 evenings, 4 hours an evening (including emergency calls), @ $4.50 an hour (time and a half)	4,572
50 Saturdays, 8 hours a day, @ $4.50 an hour (time and a half)	1,800
50 Sundays, 5 hours a day, @ $6 an hour (double time)	1,500
6 holidays, 5 hours a day, @ $6 an hour (double time)	180
Total of hourly earnings	$14,148
Plus profits on materials furnished clients (conservative estimate)	2,000
Total annual earnings	$16,148

said. Then he hung up, sighed, and said:

"These mothers! To be nice, I tell them not to hesitate to phone me; and, boy, do they take me up on it. This one calls every hour on the hour."

His accent wasn't that of a New Englander, so I asked where he came from.

"New York," he said. "My father settled here in Manchester on business, so I did too. I like it here." This last was almost defiant.

I asked him how he managed during the months, just after the trial, when he was without a license to practice.

"Well, there was about $18,000, in coins, bills, and checks, that poured out of thousands of envelopes while I was on trial. These contributions came from all parts of the country and from many people abroad, to help in my defense. We used some of the money to live on until I went back into practice.

"We have a 200-year-old house in Candia, one of the suburbs here, and I puttered around there. I shingled the hen house and plowed the garden and built a camp shack

...ere Plumbers

• Take a typical hard-working physician. Take the hourly wage scale of a skilled union man. Put the two together, and what have you got?

Well, for one thing, you've got the table shown on the opposite page. It's a fanciful comparison, to be sure—but with a hard core of facts. It suggests how medical men might fare under a union pay scale.

The figures shown are what a plumber could earn if he were willing to work evenings, Saturdays, Sundays, and holidays—and if his union would let him. Yet the doctor who actually does work these hours may come out second best. For while the union man takes home most of his pay, some 40 per cent of the doctor's earnings must be earmarked for office expenses. (Beyond all comparison, of course, are the relative lengths of training required and the relative rates of coronary disease.)

People tend to forget that a man's income is related, more often than not, to the hours he spends in meeting society's needs. This table (for all its never-never quality) may serve as a reminder of that basic fact. END

By Clayton L. Scroggins

**The author operates the Cincinnati firm, Medical-Dental Management.*

and caught up on my journals. I fixed this and fixed that and tried hard not to talk about the case or read about it. I got acquainted for the first time with my three small daughters.

"No, there was no social or personal unpleasantness from anyone. My wife noticed no difference, either, in the way she was treated by her friends. Matter of fact, you know, about 90 per cent of the residents of my community in Candia, and of the neighboring community of Goffstown, had signed a petition for my release."

I asked whether it was because these people were New Englanders that they had rallied around him.

"Not at all," he said. "I think it would have happened anywhere in America."

How did he feel on his first day back in harness?

He Felt Good

"It was like coming back to work after a vacation." He hesitated, grinning. "I suppose you're going to ask me who was my first patient and how I felt on seeing him. I don't remember who it was at all. I do recall feeling pretty good, though."

How about his economic status since "the thing" happened?

"My income has suffered some, of course. The fact that I'm barred from the hospitals has knocked out my surgical practice. But I continue to work along, minding my own business and hoping the county society will consider me favorably."

Had he thought of leaving New England after the trial?

No Lost Patients

"Not for a minute," he said emphatically. "I had offers from several other sections of the country, but I resolved to stay here and see things through. I've never regretted the decision either. I'd have been a heel to leave such fine friends and loyal patients. None of them left *me* —not one family or one patient."

We talked a little longer, about his place at Candia, his kids, and his garden. Then I got up to leave. He got up too, and put out his hand.

"I'll take back that wish about your getting stuck in the snow and catching cold," he smiled, "if you can just arrange to come down with a touch of writer's cramp instead."

I grinned back, wondering what to say along the lines of wishing him well in the re-establishment of his career, and settled for something new and different:

"Well, lots of luck, Doctor."

As I trudged back through the snow toward the railroad station, I found myself speculating that it would probably be just as well if his colleagues *did* take him back, come May. Yet no one could blame them, I reflected, if they didn't immediately restore him to the office he had formerly held within the medical society. At the time the whole thing started, he was serving as the society's public relations officer. END

In a matter of minutes...

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Everybody, from the president of the A.M.A. to Oscar Ewing, agrees that the sick poor must have good medical care. Trouble is, few men agree on the best way of providing such care.

As a result, a wide variety of indigent care plans—some good, some bad, some indifferent—have sprung up. They range from no organized plan at all, as in some Kentucky counties, to state-wide experiments like Washington's, in which a fairly complete assortment of medical services are available.

What are the ingredients of a good indigent care plan? The doctors who run the one described here think their recipe is one of the best. Other successful plans will be reported on in future issues.

Private Care for Public Patients

That, and reasonable fees for physicians set this indigent plan apart from many others

• One crisp morning last winter, a retired steel worker in Gary, Ind., slipped on an icy porch step and fractured his leg. His wife called the family doctor, who, after a brief examination, sent the man to a local hospital. There, X-rays showed a bad break. So the doctor brought in an orthopedist for consultation. The bone was set and in a few days the man was home again.

His doctor visited him from time to time to check his progress. At the end of the month, the family physician, the orthopedist, and the hospital each submitted bills for their services to the county welfare department.

This case reveals what Indiana's Lake County doctors consider the two key features of their plan for the medical care of the indigent:

1. The indigent patient gets the same private care as a paying patient. He can pick his own doctor and be sure that this doctor will handle his case in office, home, or hospital.

2. The physician gets a reasonable fee based on the services he

By Roger Menges

gives. The financial burden of care for the needy is thus put upon society rather than upon doctors.

Under Indiana law, each county runs its own program for the medical care of indigents and is given pretty wide latitude in deciding the type of program it wants. The only stipulation is that the program must have the approval of the state welfare department. Lake County's program is generally recognized as a model.

Indigent Care Economics

About 6,500 of the county's 300,000 people are entitled to free medical care. They become automatically eligible when the county welfare department grants them financial aid. Monthly cost of such care averages about $6.50 per person. The county pays 60 per cent of this, the state 40 per cent.

All but three of the county medical society's 275 private practitioners are active participants in the program. They average about $48 a month each from welfare work, although the range during any one month may run from $5 to $1,000 per doctor.

Physicians' fees account for 36 per cent of the program's cost. Other costs are divided roughly as follows: hospitals, 25 per cent; pharmacists, 14 per cent; nursing homes, 11 per cent; dentists, 8 per cent; and other costs, 6 per cent.

Why is the Lake County program so highly regarded? Partly because of good leadership—much of it provided by local physicians. Although the county welfare department legally runs the program, the county medical society has a major voice in laying down rules and regulations. And the individual doctor is largely responsible for smoothness of operation.

When an indigent patient takes sick, he simply goes to a physician of his choice. The doctor or his secretary phones the welfare department to check on the patient's eligibility, and from there on the doctor makes his own decisions. He can prescribe whatever drugs he feels are necessary (within fairly broad limits), call in a consultant, or refer the patient to a specialist. He has the authority to hospitalize the patient in whatever local hospital he chooses; and he can recommend almost any type or amount of hospital service.

At the doctor's disposal in caring for his indigent patients are drugs, appliances, special diets, and the following services: dental, hospital, nursing and nursing home, ambulance, optometric and optical, chiropodic, and clinical lab.

Following treatment, the doctor fills out, in triplicate, a report of services rendered. This includes a statement of his charge, as allowed by the approved fee schedule for welfare patients. Hospitals, druggists, and others submit similar reports.

If it's as simple as all that—if, in

other words, the patient needs no special authorization to see his doctor, what's to prevent him from making unnecessary visits? Again, that's up to the physician. He's responsible for educating indigent patients as well as private ones.

Doesn't such freedom lead to abuses? What's to stop the unethical physician from *soliciting* welfare patients? What's to keep easy-going doctors from catering to patients' whims? Who's to be the watchdog of the taxpayer's dollar?

They Watch Doctors

The watchdog is a committee of nine doctors, appointed by the Lake County Medical Society.* These men meet with the county welfare director, Fred H. Steininger, the first Monday of every month at 9 P.M. to iron out the myriad problems that are by-products of such a plan. By midnight, sometimes later, they've reviewed the 600 or so doctors' bills (usually totaling some $50,000) that have been submitted to the welfare department during the previous month.

Actually, their work is not all done in detail at this one meeting. Several days before the session, each committee member receives the bills from his section of the county. He screens them, then brings up for discussion only those that are questionable—usually about one out of five.

*Dentists, druggists, and hospitals have similar committees.

Each bill is checked with three points in mind: (1) to see that the charge is in line with the approved fee schedule; (2) to adjust the charge if there are extenuating circumstances; and (3) to review the medical procedure followed.

The fee schedule was originally set up by the reviewing committee and is revised when necessary. Although the welfare department has final say on fees, as well as all other matters, it has always approved the committee's recommendations.

The fee schedule generally allows the doctor to charge about two-thirds of what he would bill a private patient. Typical indigent fees: office visit, $2; house call (day), $3; hospital call (medical case), $2.50; consultation, $5; appendectomy, $75; obstetrical delivery, $50.

If there are complications, the doctor may be allowed a fee in excess of the one listed. If no fee has been set for a particular procedure, the doctor sets his own fee and the committee decides whether the charge is reasonable.

Although the committee is often inclined to pare down doctors' charges, it has been known to allow a larger fee than the one asked. Once made, a decision is final, unless the doctor appeals within ten days to the county board of public welfare.

A few of the committee's actions during a recent meeting:

¶ Asked a doctor to explain what a "complete examination" consisted

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As reported by investigators—

"Side reactions obtained from Neohetramine are definitely lower" than those observed from the use of most other drugs.[2]

"Only a small percentage had drowsiness"...as compared with the effects of most other drugs.[3]

"Side effects were rare..."[3]

Neohetramine "was found particularly useful in patients unable to tolerate other antihistaminic drugs."[4]

References: 1. Criep, L. H. & Aaron, T. H.: J. Allergy 19:215, 1948. 2. Criep, L. H. & Aaron, T. H.: J. Pediat. 34:414, 1949. 3. Friedlaender, S. & Friedlaender, A. S.: J. Lab. & Clin. Med. 33:865, 1948. 4. Schwartz, E.: Ann. Allergy 7:770, 1949. 5. Waldbott, G. L. & Borden, R.: Ann. Allergy 6:305, 1948.

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Nicotinamide	30	mg.
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Folic Acid	0.1	mg.
Ascorbic Acid (as Sodium Ascorbate)	100	mg.
Alphatocopherols	5	mg.
Vitamin A	10,000	U.S.P. or International units
Vitamin D	1,000	U.S.P. or International units

and also furnishes (approximate amounts):

Iron (as Ferrous Sulfate)	15	mg.
Copper (as the Sulfate)	1	mg.
Iodine (as Potassium Iodide)	0.15	mg.
Cobalt (as the Sulfate)	0.1	mg.
Boron (as Boric Acid)	0.1	mg.
Manganese (as the Glycerophosphate)	1	mg.
Magnesium (as the Oxide)	5	mg.
Molybdenum (as Ammonium Molybdate)	0.2	mg.
Potassium (as the Chloride)	5	mg.
Zinc (as the Chloride)	1.5	mg.

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of, so that it could decide whether his fee was warranted.

¶ Approved a $125 fee for a unilateral sympathectomy (scheduled fee: $100) after noting the doctor's explanation.

¶ Disallowed charges for the use of high-cost experimental medicines (which need the committee's O.K. in advance).

Keeping Up Standards

Besides focusing a sharp eye on charges, committee members also look for signs of excesses in treatment, in amount of drugs prescribed, and in hospitalization. If there's any question about the medical procedure followed, the doctor is asked for a written explanation, or is invited to meet with the committee.

Thus, one physician was asked to explain why he had hospitalized a patient for X-ray therapy treatment, usually given only on an out-patient basis. Another doctor was rebuked for the amount of drugs he had prescribed to one patient ("The patient would have had to sit up all night taking a pill every three minutes to use them up during the period medication was needed").

Committee members also keep the over-all picture in view. For example, they had long been impressed by the size of bills submitted by physicians who were making daily calls on chronically ill indigents in hospitals. Wouldn't a call every other day suffice? They agreed that often it would, and they notified doctors to that effect. At the same time, they laid down a rule of thumb to be used in deciding who should be considered "chronically ill" (any patient hospitalized for more than ten days).

This brought up another problem: the tendency of patients—particularly the chronically ill—to get lost in hospitals. Its solution: Each hospital now notifies the welfare department of every new admission. If the patient is still hospitalized after ten days, the welfare department authorizes a committee member to make a consultation visit (for which he receives $5).

Troublemakers

Do patients tend to abuse their privileges? To a degree, yes. Some want more care than is necessary. But the doctor is supposed to take a firm hand with these.

There are also, of course, a few out-and-out chiselers—like the indigent who proposed that his physician treat several of his friends and bill these services in *his* name. (The

"Aw, go ahead and have one. This isn't all there is to kids."

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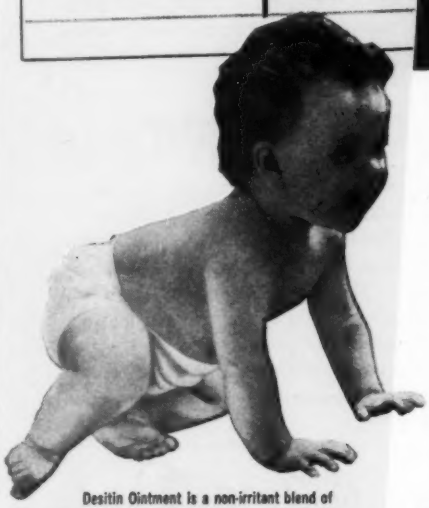

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1. Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediat. 68:382, 1951.
2. Behrman, H. T., Combes, F. C., Bobroff, A. and Leviticus, R.: Ind. Med. & Surg. 18:512, 1949.

welfare department deals with such offenders directly.)

The occasional bottom-card dealer among the doctors is spotted fairly readily. The committee's suspicions are aroused by any M.D. who appears to be seeing a disproportionate number of welfare patients, visiting them too frequently, or including too many extra charges in bills.

In one case, a physician submitted a bill of $61 for treatment of a fractured femur; but, as it turned out, he had used no splints or cast and had only given a few heat treatments. When pressed for a look at the X-ray film, he claimed to have lost it in the mail. His bill was of course disallowed—and, a little later, the county medical society put him on probation.

Doctors Speak Up

What do Lake County doctors think of the committee? Most seem to feel its decisions are pretty fair. Observes one physician:

"I got awfully mad once when they allowed me only the regular $50 fee for an OB case with complications. I had submitted a bill for $75, but I guess it was my own fault for neglecting to explain why the extra $25 was warranted. I give them all the facts now, and they're usually reasonable enough."

The doctors admit they would complain more if laymen were telling them what to do. Not that they necessarily expect to be handled with kid gloves by their colleagues on the reviewing committee. "There's actually less hell raised between the committee members and the welfare people than between the committee and participating doctors," one physician has said.

As a matter of fact, there's so little friction between the reviewing committee and the welfare department that the feeling seems to have oozed down through the ranks. Says the county medical society's executive secretary, John B. Twyman: "The traditional distrust between doctors and welfare people doesn't appear very often here. The doctors seldom gripe about the welfare department squandering money, and the welfare workers seldom refer to the doctors as money-grabbers. In fact, the social workers seem to be among the doctors' staunchest defenders."

Perhaps the major weakness of the plan is its lack of provision for people who are self-supporting but who can't afford adequate care. These "not-quite indigents" are under the jurisdiction of the county's eleven townships. It's up to each township's trustees to decide whether, and to what extent, they shall get free medical care.

A few doctors are critical about parts of the program. Some find the paper work bothersome, although the forms that physicians have to fill out have been shortened considerably in the past few years. Others are not satisfied with the fee arrangements. [*Turn page*]

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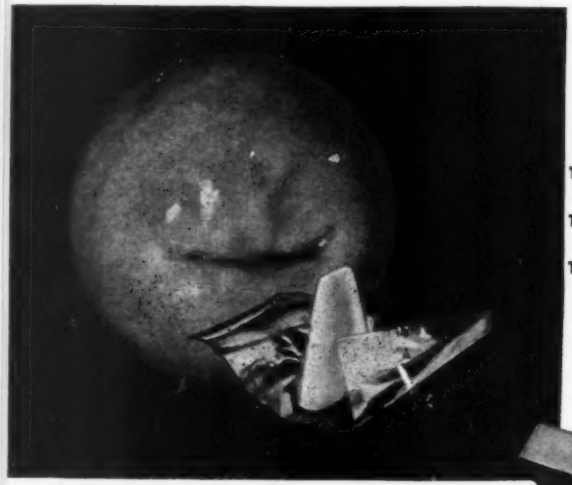

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These men contend that they should be paid the same fee for indigents as for private patients. Otherwise, as one doctor says, "the welfare patient may get the bum's rush to make way for more remunerative business."

Another physician argues that medical men are being discriminated against. He points out that hospitals get the same rate for indigents as for private patients, while doctors have to take a cut. "The reasoning seems to be that if the hospitals gave a cut rate to indigent patients, they would be taking it out on sick taxpayers. But when the doctor cuts his fee, it doesn't matter—because he's only taking it out on himself."

Such criticism, though, seems to be the exception rather than the rule. From all reports, most Lake County physicians are enthusiastic about their indigent care program. Their reaction is summed up by one of them in these words:

"We're glad to do our share to lick a serious problem. At the same time, we're not aching to shoulder the whole burden ourselves.

"Most of us think we have a first-rate program. And we know that a large part of the credit goes to the men on our reviewing committee. After all, if they were to let us ride the gravy train, we could easily run the program right out of existence."

END

"At the rate I've been working these days, if we didn't have staff conferences, I'd never get any sleep!"

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The Battle Over Birth Control

How do doctors fare when they're caught in the middle of this conflict? Herewith a revealing case report

● The theory and practice of planned parenthood long ago gained the endorsement of many medical men, as well as majority public acceptance and legal sanction in forty-six states. So it might be supposed that the physician could comfortably forget about birth-control squabbles.

But, it seems, he can't.

The conflict between birth control and Roman Catholic doctrine, far from being just a battle of ideologies, can affect physicians in some very practical ways. In most communities, the conflict is generally kept from breaking into open warfare. When it does flare up, though, medical men are apt to get burned.

In Poughkeepsie, N.Y., not long ago, a Catholic hospital gave seven doctors three days in which to make an important choice: They could either quit the Dutchess County League for Planned Parenthood, or resign from the hospital staff.

Three of the doctors, confronted with potential economic difficulties, withdrew from the league. The four others, however, challenged the hospital's right to control their outside activities. In so doing, they precipitated a battle that shook the community and touched off one of the greatest national controversies on the subject since the early days of Margaret Sanger.

Today, weeks after the headlines subsided, the four challengers still remain on both the hospital staff and the planned-parenthood league's medical advisory board. The hospital has not yet carried out its threat. Whether there will soon be another dramatic round is anyone's guess. One thing, though, is certain: The fight, whether in Poughkeepsie or elsewhere, is far from over.

As a case history, even with its final outcome uncertain, the "Poughkeepsie incident" has considerable significance for doctors everywhere. It gives a pretty good picture of how the Catholic point of view can affect physicians in particular and the community in general. Thus, the episode seems worth recounting in some detail.

Poughkeepsie, in the heart of the Hudson River valley, has two general hospitals to serve its 41,000 peo-

By Don Cameron

whether he is "middle-aged" or "aged"—

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ple and populous suburbs. Vassar Brothers Hospital (named for two nephews of the founder of near-by Vassar College) has 250 beds. St. Francis Hospital, operated by Roman Catholic Franciscan nuns, increased its capacity from 107 beds to more than 200 last fall, when it opened a new wing financed principally by $535,179 in Federal funds and by large grants from two non-Catholic philanthropies.

Ever since 1934, the Dutchess County League for Planned Parenthood has been active in the area. With the help of local physicians, it has supplied child-spacing information and clinical services to some 1,500 women. In a community slightly more than one-fourth Catholic, nobody has ever objected publicly. And for the past eighteen years, St. Francis staff doctors have assisted the league, with never a complaint or a warning.

Late in January of this year, the league sent out letters reminding its friends that the annual campaign for funds was about to begin. As usual, the letterheads listed the league's officers and the members of its medical advisory board. Perhaps somebody read those letterheads for the first time.

Doctors' Choice

At any rate, on the morning of Saturday, Jan. 26, Dr. John F. Rogers, former president of the county medical society and chief obstetrician at Vassar Brothers Hospital, visited a patient at St. Francis, where he had been on the staff for twenty-two years. Dr. Rogers was also one of the planned-parenthood league's medical advisers. He found Dr. Victor A. Bacile, chief obstetrician at St. Francis, waiting with a message.

The message was brief and to the point: Sister M. Anne Roberta, the hospital administrator, would like to hear from Dr. Rogers no later than the following Tuesday whether he'd prefer to resign from the league or from St. Francis.

"That was the gist of it," says Dr. Rogers, "and approximately the wording. Having four patients either in St. Francis or scheduled for admission, I decided for their sake to withdraw from the league—and to reconsider when they were well enough to go home."

Two hours later, Dr. Bacile delivered a similar verbal message to Dr. Albert A. Rosenberg. Dr. Rosenberg, a pediatrician, is secretary-treasurer of the county medical society and chairman of the league's medical board. He has been on the St. Francis staff for twenty years.

Dr. Rosenberg refused to quit the parenthood league. He announced, furthermore, that he proposed to continue caring for his patients at St. Francis till they barred him from the place.

Before the day was over, the Sister Roberta message had gone to Dr. Florence H. Gottdiener, the league's assistant medical director; to Dr.

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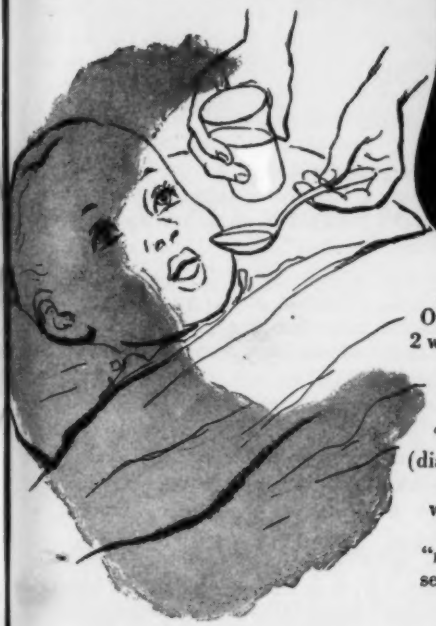

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**J. Pediat. 39:325, 1951*

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William W. Bennett, one of its medical advisers; to Dr. Martin Leiser, a part-time staffer at the league clinic; and to Dr. Paul M. Lass, who served it occasionally as a consultant.

Sunday morning, at the near-by village of Millbrook, the seventh doctor got the word from Dr. Bacile by telephone. He was E. Gordon MacKenzie, 1951 president of the county society and a member of the St. Francis staff since 1923. Two years before, the hospital had publicly acknowledged Dr. MacKenzie's help in obtaining a philanthropic grant for its building program.

To each of the physicians, the notice had come as a complete surprise —especially since all of them had been reappointed to the St. Francis staff only three weeks earlier. Each asked that the request be confirmed by letter. By Monday they knew that only the seven of them had been singled out, although at least a dozen others of the hospital's 160 staff members—including the chief of staff—were sponsors of the league or participants in its clinical work.

On Wednesday afternoon, a Poughkeepsie paper got wind of what had happened and broke the first story. Next day it was on the front pages in New York City and on the wires across the country. Battle lines were drawn. Opposing forces began to lay down verbal barrages.

A committee of Poughkeepsie's Protestant and Jewish clergymen affirmed "the high ethical principles of planned parenthood" and deplored the hospital's "attempt to police the thoughts and personal actions of individuals in our American democracy." Arguments resounded from pulpits at Sunday and midweek services.

The Catholic View

Beyond acknowledging that the order had gone out, hospital authorities refused to discuss it. But the Rt. Rev. Michael P. O'Shea, dean of Catholic clergymen in Dutchess County, asserted that the hospital would maintain its "logical and just" position.

"Everyone knows where the hospital stands on the question of birth control," Msgr. O'Shea said. "I am certain that every doctor, every Christian, and every citizen will realize that on a question like this we cannot carry water on both shoulders."

Unanswered, however, was the question of why the hospital, after waiting eighteen years, had set a seventy-two-hour deadline for shrugging the burden off one of its shoulders.

Of the physicians involved, three —Rogers, Leiser, and Lass—quit the planned-parenthood organization without a fight. All had patients in St. Francis at the time. At least two of these doctors have always relied heavily on the hospital. Deprived of its facilities, their practices would undoubtedly suffer.

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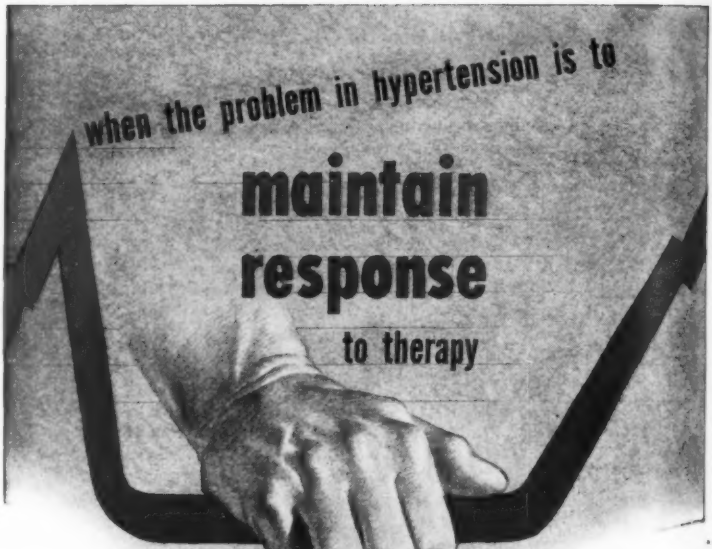

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the loss of hospital privileges, if it comes to that, but not to the same extent," one of them has said. "All of us are on the Vassar Brothers staff. On the other hand, all of us have Catholic patients, and some of them naturally prefer a Catholic hospital."

So far, none of the doctors concerned seems to have lost many Catholic patients. There have been isolated cases of patients changing doctors because of the dispute; but no real trend appears to have developed.

The Doctors Object

Most of the 230 county society members spoke out sharply against the hospital's move. At their February meeting, which had a record attendance, they set up a special committee of Catholic and non-Catholic doctors to make an independent study of the situation.

One point the committee hoped to establish was whether Dr. Bacile's oral message should be regarded as an "ultimatum." That word was flung about freely in the beginning; but it began to sound like an exaggeration as the deadline was left further behind and no formal repetition of the order materialized. How firmly—if at all—the new attitude has been incorporated into hospital policy is still undetermined.

"My personal hunch," says one committee member, "is that it might have become an ultimatum if the reaction had been less positive. The terrific publicity—nearly all of it, except in the Catholic press, good for the doctors' side of the case—may have made the hospital decide to let the whole thing drop."

But there's plentiful evidence of a continuing militant mood in the county society. "The doctors need the hospital," said one physician recently, "but the hospital also needs the doctors. If these resignations are forced, the hospital, to be consistent, would have to put the same choice to perhaps as many as twenty other staff members. A lot of them would resign, and there'd be other protest resignations, and St. Francis would have lost some of its best men and women—not to mention an incalculable amount of public support."

Temporary Truce

Signs are that the matter will *not* be forced to a head, at least in the immediate future. The doctors concerned would, of course, prefer a definite agreement that would avert future clashes in Poughkeepsie—and possibly supply a formula for settlement of similar problems elsewhere. (One suggestion, offered by a Catholic doctor, is that physicians associated with planned parenthood be accorded courtesy status on the St. Francis staff, rather than receive appointments to the active staff list.)

"We'll go along with just a tacit agreement to drop the argument, if we have to," one of the seven has admitted. "We'd rather not, though, because nothing would be settled,

and the scrap could be reopened at the hospital's pleasure."

And so, on the surface at least, the Poughkeepsie front is quiet once more. No one is willing to predict whether or when the cross fire will open up again. Meanwhile, doctors everywhere can ponder such interesting questions as these:

¶ Does the incident strengthen the case for hospital staff tenure rights, affording some protection against sudden and arbitrary dismissal?

¶ How far can a hospital justifiably go in regulating the outside activities of its staff physicians?

¶ If a hospital accepts public funds (in this case, Federal tax money), must it also accept policies favored by the general public?

¶ How should a Catholic hospital resolve conflicting loyalties to church and to community, especially when such a hospital is one of the few (or perhaps the only one) serving the area?

"We have a small apartment and we don't want to move!"

If anyone has gained from the Poughkeepsie incident, it's the planned-parenthood people. Their fund drive got off to a fine start; and, for the first time, contributions poured in from a dozen other states. By last month, they had collected four times as much as in the comparable period a year ago.

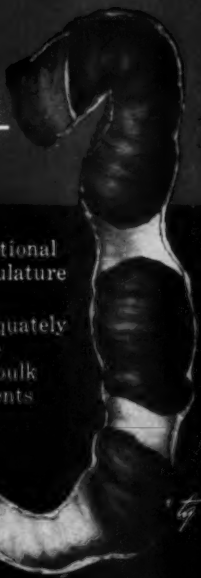
At the New York City headquarters of the Planned Parenthood Federation, which has 101 affiliated local groups throughout the United States, clippings from overseas about the Poughkeepsie affair are still coming in. William Vogt, national director, reports that the volume of news stories thus inspired has surpassed that accorded any previous case in the organization's entire history.

Meanwhile, Dr. Rosenberg continues to visit his patients in St. Francis daily and to deliver scheduled lectures to student nurses. He was the only one of the defiant four to send patients to the hospital immediately after its edict.

"Everybody at the hospital has been cordial and helpful," Dr. Rosenberg says. "Nobody has mentioned resignations. We always had a friendly spirit in this town, and I find myself having to think back now and again to be sure it wasn't just a bad dream."

There are optimists in Poughkeepsie and elsewhere who think that's all it was. END

Activation IS ESSENTIAL



In the patient with chronic functional constipation the intestinal musculature is thinned and atonic.[1]

This atrophic colon reacts inadequately to the reflex stimulation of the intestinal mucosa produced by bulk alone. Since the intestinal contents are not adequately propelled,[2] **gentle activation of peristaltic movements is essential.**

PRULOSE COMPLEX

HARROWER

In addition to methylcellulose (moist bulk), **PRULOSE COMPLEX** contains a prune concentrate fortified with an isatin derivative to provide **additional** gentle stimulation of peristalsis. **PRULOSE COMPLEX insures this activation without irritation.**

Suggested Dosage: 3 or more tablets **with a full glass of water,** twice daily, until normal elimination is established.

References:

1. Best, Charles H., M.D. and Taylor, Norman B., M.D., *The Physiological Basis of Medical Practice;* 1950, p. 591.
2. White, F. W. and Emery, E. S. *Constipation;* Nelson's New Loose-leaf Medicine, Vol. V, p. 341.

SERVING THE PROFESSION IN A PROFESSIONAL MANNER

Harrower Laboratory inc. • [illegible] •

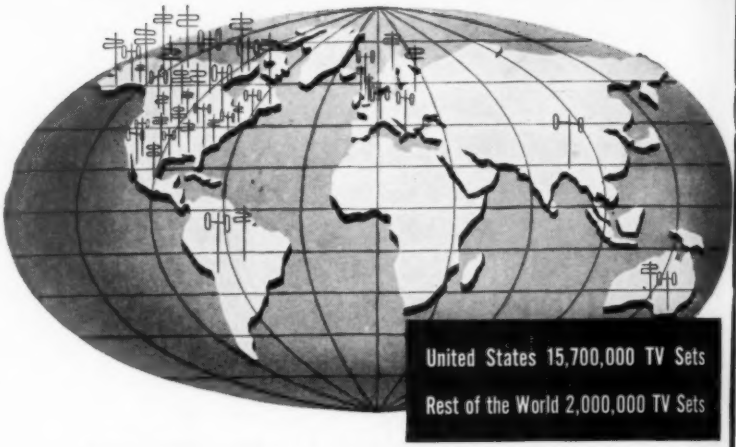
RELIEF

FOR THE DISCOMFORTS OF THE COMMON COLD

When it is imperative to reduce the fever and relieve the discomforts of the common cold, remember Anacin. The advantages of the time tried and proven APC formula, as represented in Anacin Tablets, are fully recognized—fast, prolonged analgesia with no unpleasant side effects. And the mild sedation offered is desirable to help comfort the patient. If you would like to receive Anacin samples for routine use in your practice, please make a request on your letterhead.

ANACIN®

WHITEHALL PHARMACAL COMPANY • 22 East 40th Street, New York 16, N. Y.



COMPETITION Turns Luxuries into Necessities

To millions of people throughout the world, washing machines, radios and television sets are miraculous inventions remote from their lives . . . for the wealthy only.

In the United States, however, a new product appears in no time in the homes of wage earners as well as salaried executives.

Consider television, for example. Only 6,500 sets produced in 1946 . . . over 5,000,000 in 1951. Or washing machines . . . more than 24,000,000 in 10 years.

What has Competition to do with this?

Do you think we'd continue to get more and better products if only one company made each item or each line?

No! We get more and better products here in America, because anybody who thinks he can make anything better or sell it more efficiently is free to try.

And many succeed. Take electrical products like radios and television sets . . . and home appliances like washing machines and electric fans. Does the biggest company monopolize this industry? Not by a long shot! Even counting all its affiliated companies, it still sells less than 1/5 of such products bought in this country.

There are nearly a thousand other companies that make home appliances, radios and television sets. And they do more than 4/5's of the business! The smallest of them make the biggest companies hustle their bones to keep making products better and better.

In America, a better product can always win consumer acceptance in any field.

Let's keep the COMPETITIVE SYSTEM working for us

The Competitive System can be killed! When industries are run by government, when taxes are so high that they destroy the incentive to work hard and risk savings in business ventures, the Competitive System languishes and dies.

You've seen it happen in other lands. Let's not let it happen here.

Let's all of us watch closely to see that those who represent us in government are working with us and for us to preserve our Competitive System; to assure a tax structure that leaves enough incentive to make hard work worthwhile, so that *any* man with ability and energy has a chance to earn good money and keep most of it.

Competition thrives best where the rewards are high. People live best where competition thrives.

THE COMPETITIVE SYSTEM DELIVERS THE MOST TO THE GREATEST NUMBER OF PEOPLE

Report on the Medical Schools

They're overcrowded, understaffed, and on the prowl for money

• U.S. medical schools hope to raise $250 million in the next few years. They'll spend it to expand present facilities ($100 million); to build new schools ($50 million); and for research and special projects ($100 million). Practically all the country's seventy-three degree schools and seven basic-science institutions will participate. Some of the latter plan to expand into full-scope medical schools.

Meanwhile, most schools remain badly pinched for space and have been forced to turn away a large number of fully qualified applicants. Yet some state-supported institutions—with regulations that exclude out-of-state residents—are actually having a hard time filling their rosters.

These facts, and others, emerge from a survey made by the New York Times of all medical schools and state education boards. About half the schools have already launched fund-raising campaigns, says the Times. Expansion projects—some in the construction stage, others on drawing boards—call for a total spending of $20 million on dormitories, $30 million on classrooms, and $50 million on laboratories.

New schools are planned by the states of Connecticut, Florida, Massachusetts, New Jersey, and Rhode Island. State funds will also finance the expansion of basic-science schools to degree-granting institutions in Mississippi, Missouri, and West Virginia.

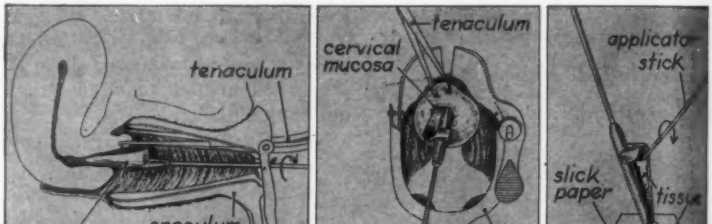
But the bullish future does little for the bearish present. Budget money is tight, says the Times; 30 per cent of the schools say they don't have enough cash to pay for current operation. Some state-supported institutions report that state legislatures demand greater enrollment—but refuse to appropriate the necessary funds for such expansion.

In addition, qualified teachers are still hard to find, according to 45 per cent of the schools. No one seems to know how the projected new or expanded institutions are going to be adequately staffed.

Most schools are bulging at the seams. Total enrollment for the nation is 26,000, as compared with 23,000 five years ago. Freshmen total 7,381, also the highest number in years.

And there would be even more

Clay-Adams News



NOLAN-BUDD Cervical Biopsy Curet

FEATURES...New curet* means *simple procedure for the doctor*—can be carried out in the office without anaesthesia. *Simplifies work of pathologist*—utilizes routine paraffin embedding, microtome sectioning, staining with hematoxylin and eosin, and microscopic study.

CLINICAL PROCEDURE

No anaesthesia is required. The cervix is grasped with a tenaculum. The curet is introduced gently into the cervical os with rotation in a counter-clockwise direction until it is inserted as high as possible in the canal. The material collected in the cup is then transferred to the surface of a small square of paper with an applicator stick.

MICROSCOPIC TECHNIC

The collected blood, mucus and tissue are fixed and embedded as with other tissue specimens. Staining is carried out in the usual manner with hematoxylin and eosin. Time for preparation is the same as for other routine biopsies. Examination is facilitated since the tissues are concentrated in a small space on the slides.

E-425/55 Nolan-Budd Cervical Biopsy Curet...ea. $20
Form 5158 gives complete details.

**J. F. Nolan, M.D., and J. W. Budd, M.D., Los Angeles Tumor Inst., Cancer, 4, 6, Nov. 1951, pp. 1367-1371.*

freshmen if the schools could take them. About 20,000 men and women tried to enroll last fall. They sent out 70,000 applications, or an average of 3.5 per person. Some who were rejected have turned to foreign schools.

About half of all applications came from seven states: New York, Pennsylvania, California, Illinois, Ohio, New Jersey, and Texas, in that order. Half the Texas applicants were accepted, but only 29 per cent of New York's.

It grows increasingly hard for an out-of-state applicant to gain admission into a state-supported institution. For instance, seventeen state-operated schools currently exclude out-of-state residents, compared with only nine in 1948, seven in 1947, and none in 1946.

More than half the state schools give preference to residents; some admit only two or three out-of-staters to a class. Last year, more than 93 per cent of the freshmen in state-operated schools were residents, compared with 83 per cent ten years ago.

The schools with exclusion policies have found applicant screening easy. According to the survey, seven of them last fall had only 2¼ applications for every opening, while twelve nonrestrictive schools averaged nineteen applications per opening.

By using exclusion to pry themselves out of one tight spot, however, a number of state schools have backed into another one: They haven't been able to find enough qualified students to fill their freshman classes. As a result, they've been forced to accept applicants with grades of low B or C, while private schools can't find room for those with A's and B's. "Some state schools," says the Association of American Medical Colleges, "are literally scraping the bottom of the barrel in order to fill their needs."

END

No Happy Returns

● It happened at the aircraft plant where I was an industrial nurse. The doctor in charge was young but extremely serious and businesslike. One day he was giving a routine physical to a new employe, a young lady who obviously distrusted the whole procedure. When the doctor started to place his stethoscope inside her low-necked blouse, it was just too much for her. Angrily, she pushed his hand away and shrilled, "Say, whaddya think this is —ya birthday?"

—R.N., WASHINGTON

'Explain That Doctor Bill!'

How to set patients straight about consultants' fees, hospital charges, and other economic facts of life

• By one of those peculiar turns that American expressions sometimes take, the phrase "the doctor bill" has come to have a broader meaning than it ought to. This fact, says Dr. Cyrus W. Anderson of Denver, has led to many a rift between physician and patient.

The rub, he explains, is that "the doctor bill" is now a convenient, inclusive synonym for "all medical expenses." More and more, when people use the term, they mean not only the fee charged by the doctor, but also the cost of ambulance service, appliances, hospitalization, nursing care, and drugs. It's no wonder, then, says Cyrus Anderson (who is chairman of the board of trustees of the Colorado State Medical Society), that the hapless doctor often takes the rap for the "high cost of medical care."

You've probably heard many stories in which the phrase "the doctor bill" is misused. And more often than not, such stories have a villain: the physician. During a recent A.M.A. public relations conference, Dr. Anderson cited a common example:

"Almost every day there are news items involving someone—usually a child—who has a serious ailment, is unable to procure the services of a specialist . . . and must wait until friends and sympathizers contribute to a fund which will cover the 'doctor's bill.'" The reader often gets the idea that the doctor won't help out until he's sure of getting paid.

Physicians, Dr. Anderson thinks, are somewhat to blame for these mistaken impressions. Reason: They fail to explain to their patients the basic facts of medical economics.

Take routine blood and urine tests, for instance. Says Dr. Anderson: "You send Bill Jones into the hospital. The chances are . . . that you just completed the examination of his blood and urine [in your office] . . . The first thing that happens to him when he gets comfortably settled . . . in the hospital [is that he's asked for] another blood specimen, and he is also asked for another specimen of his urine."

Not understanding that such tests are, for good reason, a routine part of hospital procedure, Jones may well be peeved, says Dr. Anderson,

Unusually Precise Evaluation of Ir

Recent Report Shows Value of New Biochemical Determinations*

"Six weeks of oral iron (Mol-Iron) therapy will in the anemic mother produce the equivalent of 4 transfusions at a fraction (1/40) of the cost"*

In an unusually thorough clinical study recently reported, Lund* was able to diagnose the presence of true iron deficiency anemia of pregnancy and to evaluate *with a high degree of accuracy* its response to therapy.

NEW DETERMINATIONS SHOW TRUE BLOOD PICTURE

Accuracy in diagnosis and evaluation of response to treatment was made possible by combining new biochemical diagnostic determinations—*blood volume, erythrocyte protoporphyrin, total hemoglobin mass* —with hematologic studies routinely used in clinical practice. These newer techniques permit a more accurate appraisal of the anemic state and its response to therapy since they take into account the definite but widely varied increases in plasma volume that occur during pregnancy. Such increases in blood volume, of course, considerably limit the usefulness of routine blood counts during pregnancy.

THERAPEUTIC RESPONSE TO MOL-IRON

". . . the oral administration of a molybdenum ferrous sulfate compound (Mol-Iron) effectively treated 95 per cent of a group of . . . patients with iron deficiency anemia of pregnancy."

Six weeks' treatment with Mol-Iron—providing 240 mg. elemental iron daily—produced *increases in total hemoglobin mass of 80 to 87 per cent.*

"In the severely anemic patient molybdenized ferrous sulfate (Mol-Iron) will assist in the regeneration of 45 Gm. of hemoglobin per week *or the equivalent of a 350 cc. blood transfusion.*"

The author observed an average

*Lund, C. J.: Studies on the Iron Deficiency Anemia of Pregnancy, Am. J. Obstet. & Gynec. *62*:947 (Nov.) 1951.
(Reprint available upon request)

Iron-Deficiency Pregnancy Anemia

hemoglobin gain of 2.9 Gm. per cent in 4 weeks of Mol-Iron therapy during late pregnancy; this is almost identical with the frequently reported figure of 2.8 Gm. per cent in 3.7 weeks following *intravenous* iron.

RESPONSE TO MOL-IRON THERAPY

		BEFORE TREATMENT	WEEKS OF TREATMENT					
			2		4		6	
	TIME	MEAN	MEAN	% INCREASE	MEAN	% INCREASE	MEAN	% INCREASE
Hgb. Gm. %	Early*	7.4	8.9	13	9.6	26	9.7	28
	Late†	7.1	9.0	20	10.0	36	10.6	47
Total hgb. Gm.	Early	327	416	27	512	56	612	87
	Late	335	407	20	507	54	595	80

*Treatment initiated during the period of rising plasma volume (before 32 to 34 weeks gestation).
†Treatment initiated thereafter.

WELL TOLERATED

Of a total of 75 patients receiving Mol-Iron therapy, Lund observed only one (1.3 per cent) who was unable to continue the medication because of gastrointestinal disturbances.

SUGGESTED THERAPEUTIC PLANS

"The results of this study suggest the following therapeutic plans. If the anemia is discovered during the first or second trimester, active treatment with iron will not only restore the normal amount of hemoglobin, but will also reproduce the normal increase in total hemoglobin. Treatment may be stopped at delivery. If the anemia is discovered during the last trimester, full normal response is not usually obtained before delivery; in such cases the treatment should continue for 6 or 8 weeks postpartum."

COMMENT

Utilizing newer biochemical determinations, this study* indicates that Mol-Iron is an exceptionally effective iron preparation. Thus it gives strong emphasis to the already extensive evidence that has accumulated demonstrating the definite therapeutic superiority of Mol-Iron.[1-8]

Mol-Iron supplied as: Mol-Iron Tablets, Mol-Iron Liquid, Mol-Iron Drops, Mol-Iron with Calcium and Vitamin D (capsules), Mol-Iron with Liver and Vitamins (capsules). White Laboratories, Inc., Kenilworth, N. J.

1. Dieckmann, W. J., and Priddle, H. D.: Am. J. Obstet. & Gynec. *57*:541, 1949.
2. Dieckmann, W. J., and Associates: Am. J. Obstet. & Gynec. *59*:442, 1950.
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when he finds that he's been charged several dollars for the same test he got at the doctor's office shortly before. In every such case, the Denver surgeon suggests an ounce of prevention: Tell the patient beforehand what tests are routine and why.

Frequently, Dr. Anderson has found, people also take exception to hospital charges for tissue tests. When a person learns that he has been charged $10 for "examination of tissue," he's likely to ask, "*What* tissue?" And the question is not entirely unwarranted.

Here, again, the doctor should take time to explain in advance. He might, for example, point out that "By these routine examinations cancer might [be] detected" and, if by any chance it were, the examination would obviously be worth a "hundred times the small cost."

Explaining Drug Costs

Drug costs also require some explanation, the Colorado doctor says. He asks his colleagues: "Do you warn your patient that sixteen capsules [of a certain drug] will cost him approximately $9.60? . . . Do you tell him that although these so-called wonder drugs seem terribly expensive, in the vast majority of cases they actually save him money? . . . You know these facts, but your patient doesn't know them until you tell him."

Nowadays, says Dr. Anderson, most people understand that they'll have to pay for a visit to a consultant's office; but they still don't understand the consultant's place in the hospital. While an anesthesiologist is a consultant, "a good many surgeons forget that fact and take it for granted that the patient should know . . . there will be an extra charge for such services." Dr. Anderson suggests that the M.D. introduce his patient to the anesthesiologist in some such manner as this:

"Mrs. B, I feel more at ease operating when I have Dr. A administering the anesthetic. I would like him to give you yours. You know, if *I* were to be operated on tomorrow, I would be more concerned about who was going to put me to sleep than I would [about] who was to do the cutting."

Three 'Don'ts'

To assure good physician-patient-consultant relations, Dr. Anderson offers three "don'ts":

"1. Don't fail to obtain consent for a consultation whenever possible, and make it clear in advance that there will be a separate bill from the consultant.

"2. Don't tell a patient what another doctor's fee should be.

"3. Don't be guilty of featherbedding . . . The rules of some specialty boards tend to cause a member to lean [toward such a practice]."

While explaining "those other costs," the M.D. should also explain his own charges, says Dr. Ander-

son. He suggests abolition of the time-worn phrases "For services rendered," since patients have made it clear, he says, that they want to know *what* services.

The doctor can satisfy a patient's curiosity by itemizing his bill and mentioning *all* services rendered, Dr. Anderson asserts. He adds: "If, for instance, you failed to charge Bill Jones for that blood and urine you examined in your office, because you knew he was going to have it done over again in the hospital, let him know about it in a modest way."

Dr. Anderson admits that the job of explaining "the doctor bill" takes some time and effort. Yet he believes most of the things that are hazy in the patient's mind can be cleared up in the course of normal conversation. Medicine's public relations men are doing a fine job, he says, but "nothing supplants the word-of-mouth instruction direct from the doctor." END

The Medical Care Dollar

Source: Department of Commerce

THE TRUTH ABOUT
FROZEN ORANGE JUICE

Significant Dietary Advantages Of Fresh-Frozen Minute Maid Orange Juice Over Home-Squeezed Orange Juice Shown By Independent Research

RECENT assays[1] emphasize the nutritional superiority of reconstituted Minute Maid Fresh-Frozen Orange Juice over home-squeezed orange juice in three respects:

a. Average levels of natural ascorbic acid were significantly *higher* in Minute Maid;

b. Peel oil content was significantly *lower;*

c. Bacterial counts were dramatically *lower.*

Two reasons for Minute Maid's higher ascorbic acid content are advanced:

First, oranges vary widely in ascorbic acid content.[2] Thus, whole oranges squeezed a few at a time provide a highly erratic source of Vitamin C. Each can of Minute Maid, however, represents the pooling of juice from hundreds of thousands of oranges; thus wide variations in nutrients tend to be eliminated.

Second, because it is frozen, Minute Maid loses none of its ascorbic acid content before reaching the consumer.[3] Whole fruit, however, is subjected to variations in temperature, and care in handling cannot be maintained from tree to table. Laboratory tests have shown an average ascorbic acid loss of 10.7% in whole oranges after 11 days under simulated storage and shipping conditions.

Peel oil, cause of allergic response and poor tolerance, especially in infants,[4] is held to an arbitrary minimum in Minute Maid. Samples of home-squeezed juice expressed by typical housewives showed peel oil contents up to 700% higher.

Bacterial counts were found to be as high as 350,000 per ml. in home-squeezed samples—but were uniformly low in Minute Maid. Technicians ascribe this to the combination of rigid sanitary controls in the Minute Maid process and the low pH and low temperatures at which the juice is kept. High bacterial counts in home-squeezed juice are doubtless due to contamination from the exterior peel which is unknowingly added to the juice during preparation.

In view of the above findings, more and more physicians now specify Minute Maid Fresh-Frozen Orange Juice in lieu of home-squeezed orange juice.

REFERENCES

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(2) U. S. Department of Agriculture Technical Bulletin No. 753, December, 1940.

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Wallace R. Roy, Ph.D., Director of Research

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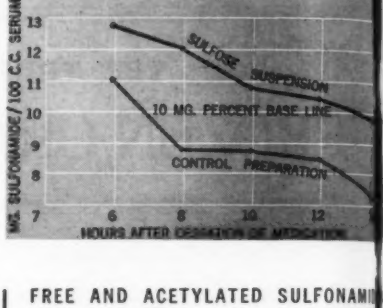
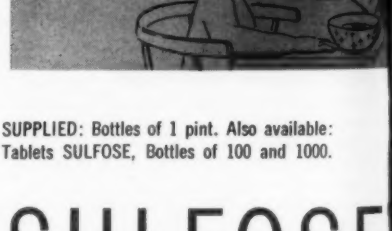


ss danger of renal crystallization
acid urine than with any "single"
fonamide used in general systemic therapy.

ısually palatable
e to encourage cooperation of your patients.



SUPPLIED: Bottles of 1 pint. Also available: Tablets SULFOSE, Bottles of 100 and 1000.

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SULFOSE

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PHILADELPHIA 2, PA.

Letters to a Doctor's Secretary

Some pointers on the right way to handle office mail

• DEAR MARY: In my letter on blueprinting your day, I listed the duty of "opening the mail and disposing of it through proper channels." I now want to enlarge upon that.

In no type of office is answering the mail more important than in a doctor's. In none is it more often neglected or improperly performed.

If you want an almost faultless example to follow, take note of the letters Dr. Barrie receives from members of the Mayo Clinic. To begin with, if you write them a letter, you may depend upon their answering it the day it is received. It will be answered fully and courteously. The reply will be written on a fine quality of engraved white stationery. It will be correctly and artistically spaced on the page. The typing will be even and clean cut. It will be signed by the doctor from whose department it comes, not by his secretary. In sixteen years of rather frequent correspondence with members of this clinic, I've never seen an erasure or a misspelled word.

A pretty high standard? Yes. But why not? You're proud of your doctor and his work. It's up to you to see that every bit of correspondence going out of your office bears the imprint of perfection—symbolic of its source.

Suppose we now go through a large batch of mail together, as though I were there beside you. And suppose it contains just about every type Dr. Barrie receives.

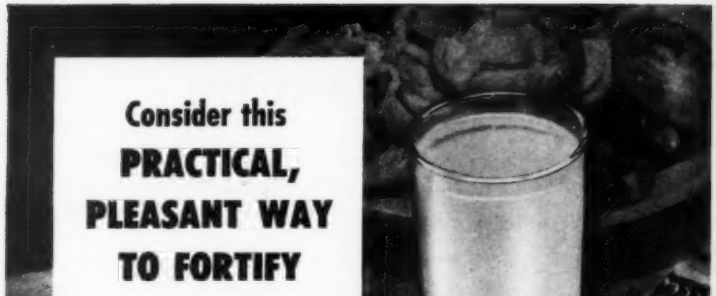
As you open the mail, you separate it into small stacks according to subject matter. In the first stack are checks, money orders, and all letters dealing with questions of fees or collections.

We enter in the ledger under "Cash Received" the various names and amounts. We endorse the checks and money orders with the

---

By Anna Davis Hunt

**These letters were published originally as a series in* MEDICAL ECONOMICS, *signed with the nom de plume Myrna Chase. In response to a great many requests, they are now being reprinted in revised and updated form. The complete current series, of which the present letter is the sixth, will be made available in a portfolio.*



The inclusion of Vitamin A-D fortified skim (or partially defatted) milk in low-fat high-protein diets has been found highly beneficial in all these cases . . .

☑ **INFANT FEEDING**—superior weight gains, improved appetite where apathetic to regular milk, apparent better utilization of Vitamins A & D in aqueous form.

☑ **PREGNANCY & LACTATION**—an even richer protein source than whole milk—enhances resistance to edema, toxemia, anemia, hypertension.

☑ **GERIATRICS**—increased vitamin, calcium & protein requirements, limited fat intake—are ideally met.

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- **VITEX NATURAL "D" AND UVO® IRRADIATED ERGOSTEROL**—for quality Vitamin D Homogenized Whole Milk.
- **"MULTI-MIX"***—new multiple vitamin-mineral concentrate.

*Trade Mark Nopco Chemical Co.

For further detailed information, write for bulletin #V-95-8 to . . .

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Pioneer Producers of Vitamin Concentrates for the Dairy Industry

NOPCO
EVOLVED THRU RESEARCH

doctor's rubber stamp, list them on a bank deposit slip in the order in which they are entered in the ledger (making a carbon copy), and put them safely away until it's time to go to the bank.

If there's a return address on an envelope, we compare it with the one on the patient's ledger card. If the patient has moved, we note the new address on the card. If the payer is one whose willingness or ability to make further payments is doubtful, we also note on his card the name of his bank. (It isn't a bad idea to do this in every case.)

We then make out receipts for all patients who have sent in routine payments. Many offices don't mail receipts for checks, but I beg you not to neglect doing so—for two good reasons: It gives the patient the feeling that his payments are appreciated. And it shows him how much (if anything) he still owes.

A kindly personal note is written to anyone whose payment is at all unusual, or whose payment is accompanied by a letter. Examples:

Dear Mr. Gardener:

Thank you for your $200 check in full payment of your wife's account.

Thank you, too, for your gracious note of appreciation. It means more to me than I can tell you.

Mrs. Gardener was a delight-

"Yes, I know the other doctors differ from me in the diagnosis of your case But the post-mortem will show I'm right!"

NO BORIC ACID!

Diaparene® CHLORIDE

(METHYL BENZETHONIUM CHLORIDE)

BACTERICIDAL • WATER-MISCIBLE • SAFE[2,3]

The ever-present possibility of boric acid poisoning by transcutaneous absorption, when the skin is broken, indicates the physician's and nurse's need of making sure to recommend to every mother a "diaper rash" dusting powder and ointment containing *no boric acid*.

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3. Niedelman, M. L., et al.: "Ammonia Dermatitis: Treatment with Diaparene Chloride Ointment," J. Ped. 37:5-762, Nov., 1950.

PHARMACEUTICAL DIVISION, HOMEMAKERS' PRODUCTS CORPORATION, NEW YORK 10

ful patient, and it was a real pleasure to be able to aid in her recovery.

My kindest regards to you both.

Sincerely,

Dear Mrs. Aldrich:

Thank you for your check for $25. This is the fourth and final payment on your account of $100. Receipt in full is enclosed.

Let me take this opportunity to tell you that I appreciate the promptness with which your payments have always been made.

Kindest regards and very best wishes.

Sincerely yours,

Dear Mr. Davis:

Your letter asking that we reduce our fee for professional services from $50 to $30 has been received.

We thank you for being so frank about your situation and for explaining it so fully. However, we were aware of the facts and carefully took them into consideration before setting the fee.

We feel that $50 is a fair charge, considering not only your financial circumstances but the gravity of the condition treated and the scale of fees observed by other local physicians. We are therefore re-enclosing our bill for $50, with the assurance, however, that we shall be glad to allow you three months in which to pay.

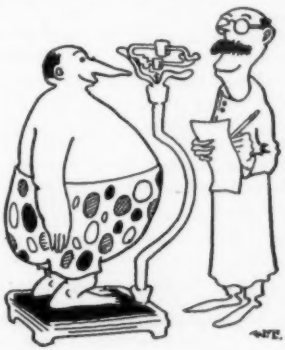
Cordially yours,

You see, Mary, the idea is that we want to write as many letters—not as few—as possible.

Each one must be aimed individually. Form letters have little place in a doctor's office. Both the man who has paid a large fee and the woman who has struggled to pay a small one like to be thanked and appreciated. Our letters are an excellent public relations activity, and they create untold goodwill.

You may have noticed that through all my instruction to you there runs a stream of what might be called economic consciousness. This is true, and it calls for no apology. Much of your value to Dr. Barrie lies in the vigilance with which you nurture his financial interests and the sources from which they flow. If *you* are expert and never-failing in this respect, *he* doesn't need to be.

His mind can then be left free for the professional aspects of his practice, and he will be able to increase



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Veriloid, a product of Riker Laboratories research, is an alkaloidal extract of hypotensive principles obtained by fractionation from Veratrum viride. It is freed from the dross of the mother substance. Biologically assayed in mammals, with drop in blood pressure as end point. Generically designated alkavervir.

1. Uniformly potent; constancy of pharmacologic action permits exactitude in dosage calculated in milligrams . . .
2. A unique process of manufacture produces a tablet which dissolves slowly, thus assures Veriloid absorption and action over a considerable period . . .
3. Moderates blood pressure by vasorelaxant action independent of vagomotor effect . . .
4. No ganglionic or adrenergic blocking . . .
5. Lability of blood pressure, so important in meeting the demands of an active life, is not interfered with; no danger of postural hypotension . . .
6. Cardiac output is not reduced . . .
7. No compromise of renal function . . .
8. Cerebral blood flow is not decreased . . .
9. Tolerance or idiosyncrasy rarely develops . . .
10. Hence can be given over long periods in the aim to arrest or lessen progression of hypertension . . .
11. Well tolerated in properly adjusted dosage; does not lead to headache . . .
12. Produces a prompt and sustained drop in blood pressure in all forms of hypertension.

Veriloid is available in 3 dosage forms: Veriloid (plain) in 1, 2, and 3 mg. tablets; Veriloid-VP (Veriloid, 2 mg., and phenobarbital, 15 mg.); Veriloid-VPM (Veriloid, 2 mg., phenobarbital, 15 mg., and mannitol hexanitrate, 10 mg.).

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his usefulness to humanity in proportion. So if I speak occasionally from the standpoint of the doctor's financial success, it is because you should concern yourself with it more than he does.

Don't think for a minute, however, that there are not greater considerations. There are. And they lie as a firm foundation under all other aspects of practice. This foundation of training, ability, skill, and true humanitarianism is what makes it possible for you to serve your doctor's economic interests conscientiously and enthusiastically.

But to get back to our letters:

Learn how to compose and write them yourself, for here's one excellent way in which you can save the doctor's time.

Out-and-out collection letters are, with few exceptions, the only ones that bear your own signature. Dr. Barrie's name should appear on virtually all others. Naturally, a carbon copy of every letter is made for the files.

In the second pile of mail we find two letters from doctors requesting information about patients who have been operated on by Dr. Barrie. There's also a note from a patient asking that an enclosed insurance blank be filled out. We get these three patients' records out of the files, type a résumé of the first two in duplicate, and write a short friendly letter to each of the doctors. From the third record we fill out the insurance blank, making a copy for reference, and write a note to the patient.

In the next batch are several announcements from physicians who have opened new offices, together with a number of reprints from other doctors. A short but very personal and appreciative note is written to each, congratulating or thanking him, as the case may be. Be careful to address the doctor by his first name, if he is a friend of Dr. Barrie. Example:

Dear Roy:

Your handsome announcement was in my mail this morning. I want to congratulate you on your move and tell you I believe it will be greatly to your advantage.

At the first opportunity I shall give myself the pleasure of dropping in to admire the new office. Meanwhile, my best wishes for ever increasing success in your new location!

Cordially yours,

Where Charity Begins

In the next division of our mail we find a number of solicitations for charities. Don't just throw them in the wastebasket. Some may be from people who know Dr. Barrie socially, or from past or potential patients. Besides, most of them represent worthy causes, wholly deserving of courtesy. Any man, however, whose income is well regulated has his charitable donations thoughtfully budgeted and does not give indiscriminately on the strength of an

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A SINGLE APPLICATION USUALLY SUFFICES IN

SCABIES AND PEDICULOSIS

The dependable efficacy of Kwell Lotion as a scabicide and pediculicide makes possible, in most patients, complete eradication of either scabies or pediculosis by means of a single application. Kwell Lotion is non-irritant and does not lead to secondary dermatitis or skin irritation, even when applied to the skin of children or in the presence of secondary infection.

Kwell Lotion contains one per cent gamma benzene hexachloride incorporated in a water-miscible, greaseless and stainless lotion vehicle. Pleasantly scented, it offers the utmost in convenience and patient acceptability.

Available in 2 ounce and 1 pint bottles on prescription at all pharmacies.

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KWELL OINTMENT

Kwell Ointment offers the therapeutic virtues of Kwell Lotion in a pleasantly scented vanishing cream base. It is useful especially in the treatment of scabies in younger children where prolonged skin contact must be maintained. Supplied in 2 ounce and 1 lb. jars.

eloquent plea. In other words, Dr. Barrie should no more scatter his fire in this particular than he should try to practice six specialties. Your answer to these pleas, therefore, may run something like this:

Dear Mrs. Brownleigh:

Your very interesting letter in regard to maintenance funds for the "Kiddies' Kookie Krock" has been received.

While we realize fully the worthiness of your request, we are obliged to decline membership at this time since Dr. Barrie's heavy budget for charitable institutions has already been allocated for the year.

With best wishes for your success, I am

Sincerely yours,

Secretary to Dr. William Barrie

The refusal to a begging letter is another of the few instances where you should, for obvious reasons, use your own signature.

The next stack of mail is from relatives and friends. This you leave for the doctor or his wife to answer; although, before long, Dr. Barrie will probably be saying to you, "Here, *you* answer this letter from Johnnie. Tell him so and so . . . and so and so." Then it'll be up to you to frame his brief remarks into a letter of which the recipient will say, "Now, doesn't that sound just like Bill?"

In the next bunch—which often seems largest of all—are bills. All of these that lie within your jurisdiction, such as the ones for laundry or office supplies, are checked over carefully with the invoice to see that they are correct. Dr. Barrie's personal bills are placed on his desk for approval.

When bills have been O.K.'d by you or him, they are put away in a drawer reserved for that purpose, until the tenth of the month. No matter on what date they arrive, *all* bills, large or small, are paid by *check* on the *tenth*.

The last pile of mail contains advertisements. If they're of possible interest, you show them to the doctor and find out which ones he wants to follow up for samples and literature.

After all outgoing letters have been perfectly spaced and typed, they are placed in a neat pile on Dr. Barrie's desk for his inspection and signature. You are then ready to go on with the next division of your work.

Later in the day you may have to write some more letters—thanking doctors for referring patients, reporting on these patients, etc.—but they will not vary greatly from the types already discussed. Obviously, all letters describing actual treatment or surgical procedure must be dictated by the doctor himself.

Every letter that leaves the office should be signed by either the doctor or you. No halfway measures. I mean, never resort to the common

practice of signing his name and adding your initials. This says, as plainly as though Dr. Barrie had said it, "This letter is from me to you, but you are not of enough importance for me to take time to read and sign it."

I well remember Dr. Barrie's disapproval on receiving a letter from a budding young doctor to whom he had referred a patient. This letter, reporting on the patient's condition, bore the archaic legend, "Dictated but not read." Dr. Barrie scrawled across the bottom of it, "Returned to be read by the doctor so that I may know whether the record is correct." He signed his name and told me to send it back.

Of course you know that the title "Doctor" is never used in the signature. Below the signature, at the lower left-hand side of the sheet, are placed the doctor's initials followed by your own, as WB:M. If the letter contains enclosures, this fact is noted below the initials, like this: "3 enclosures."

Letters of inquiry from other doctors, or from anxious patients or their relatives, should be answered the day they are received.

If Gifts Arrive

Professional associates who have been treated without fee, as well as grateful patients of all classes, frequently send the doctor gifts. These can range from a costly oil painting to a carton of cigarettes. Etiquette demands that gifts be acknowledged within twenty-four hours of

Through the Menstrual Years of Life . . .

THE frequency with which the menstrual life of so many women is marred by functional aberrations that pass the borderline of physiologic limits, emphasizes the importance of an effective uterine tonic and regulator in the practicing physician's armamentarium.

In ERGOAPIOL (Smith) with SAVIN the action of all the alkaloids of ergot (prepared by hydro-alcoholic extraction) is synergistically enhanced by the presence of apiol and oil of savin. Its sustained tonic action on the uterus provides welcome relief by helping to induce local hyperemia, stimulating smooth, rhythmic uterine contractions and serving as a potent hemostatic agent to control excessive bleeding.

May we send you a copy of the booklet "Menstrual Disorders", available with our compliments to physicians on request.

MARTIN H. SMITH COMPANY
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the purging parent...

She boasts of keeping the poor child's bowels "wide open."

Instead of keeping the youngster healthy, she is establishing a laxative limp in the digestive tract.

Turicum, giving ***lubricoid action without oil,*** affords sane therapy without irritating the bowel.

Turicum is not a one-dose cathartic. It is a treatment which, taken over a period, helps restore a gentle, symptomless, normal bowel function.

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their receipt. A warm, friendly note of appreciation, signed by the doctor himself, is essential.

When the subject matter of a letter is something properly dealt with by the secretary (collections, for instance), it should be written by you in the first person and signed with your full name over the line, "Secretary to Dr. William Barrie." All other letters should appear to have been written by Dr. Barrie in the first person and should be signed by him. Even if, when rushed, he should tell you to sign his mail yourself, you must copy his signature as closely as possible and leave off your own initials.

In these letters you compose, don't be afraid to let yourself go. The more style and originality they show, the better. If the doctor doesn't like them, he won't hesitate to say so and will dictate others These you must study so as to absorb thoroughly his ideas, reactions, and style. Not until you have done this can you be called a *secretary* in the true sense of that much misused word.

Yours as ever,
Myrna Chase

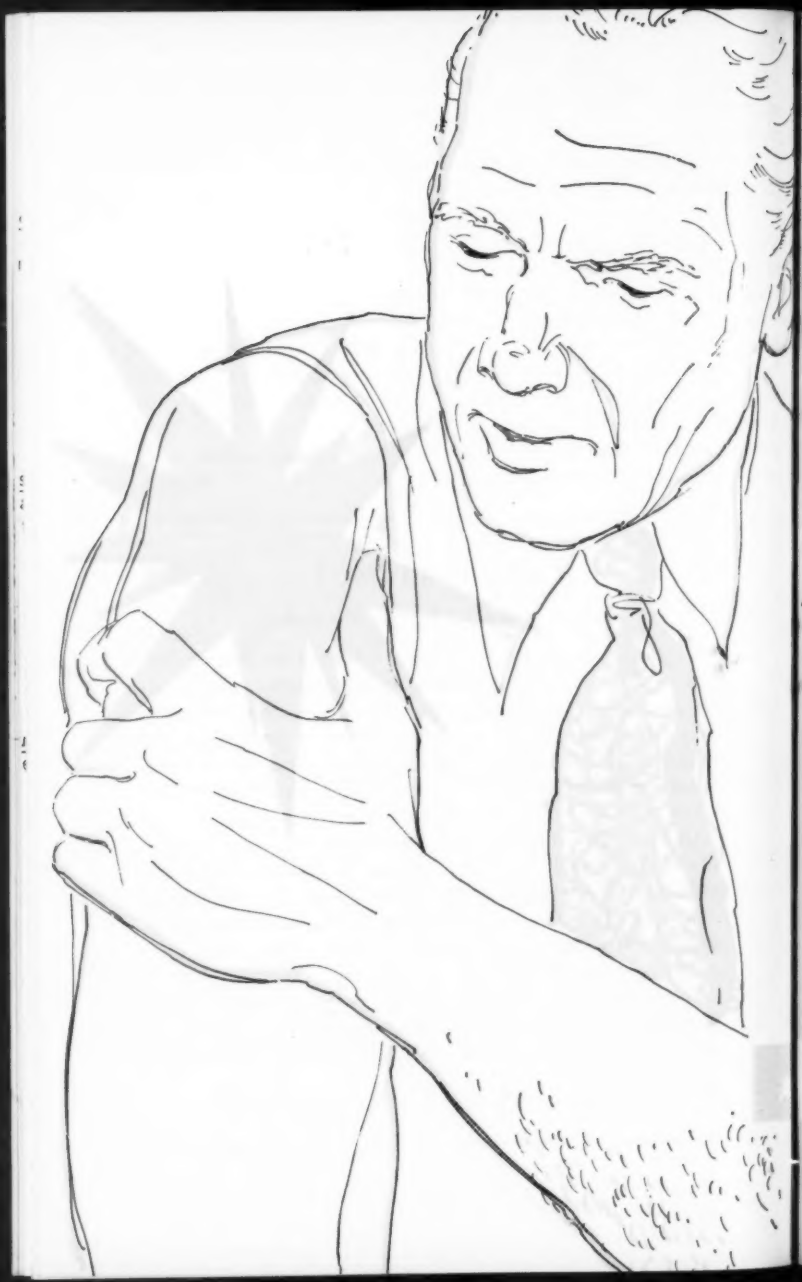
Pediatrician No. 1

A book review by Ross C. McCluskey

● He was a German Jew—a political refugee from Prussia. He came to the U.S. with a Viennese medical degree, and in no time at all began telling American doctors they often did more harm than good. He was fired from a New York hospital for alleged cruelty to children. He married an American woman doctor (an ardent feminist to boot) at a time when women doctors were considered abnormal creatures.

All in all, Dr. Abraham Jacobi seemed destined for a niche behind the eight ball. Yet he became the world's first child specialist, the first professor of pediatrics (actually the founder of the specialty), the first head of the pediatrics section of the American Medical Association, and, in 1911—at the age of 81—president of the A.M.A. itself.

These facts will, of course, come as no great surprise to any physician with more than a passing interest in the history of medicine. What Rhoda Truax has produced in [*Turn page*]



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this book* is a "popular" biography –and unfortunately it has many of the shortcomings of that genre.

The lay reader may gain considerable insight into the problems that medicine faced a century ago. But the doctor will regret that Miss Truax has omitted most of the more revealing clinical details of the pioneering careers of Abraham and Mary Putnam Jacobi.

Bedside Doctor

Jacobi lived in the age of such lustrous men as Osler, Pasteur, and Lister. But he was no medical comet; he considered himself only a good bedside doctor. As such—and as a teacher—he had a truly profound effect on medicine.

The bedside is the place to learn medicine, he told his students; never give up watching the patient. This was a startling notion; for it was a popular saying of the day that doctors could gain experience only when they had their own practices and their own cemeteries. Jacobi was to change all that.

"Bedside teaching in pediatrics antedated bedside teaching in internal medicine in the United States," Dr. Fielding H. Garrison is quoted as saying. "He [Jacobi] rescued pediatrics from the protecting but often hindering skirts of gynecology; hitherto timidly sharing the crowded seat of obstetrics, it was now placed in a chair of its own."

*"The Doctors Jacobi." By Rhoda Truax. Little, Brown & Co., Boston. 270 pages. $3.50.

Most doctors of his era were content to make a diagnosis and then let nature take its course. Even Viennese doctors, Jacobi said, "threw up their hands at the idea of doing something for the patient. They felt he and you were supposed to meet only twice, once on the hospital bed . . . again on the autopsy table."

Jacobi landed in America in 1851. He was reasonably successful from the start, says his biographer. But he soon turned to children—perhaps, says Miss Truax, "because babies were so helpless; even less than privates in the army, they could not complain and they could not vote."

That is a cozy explanation; but the truth probably is that Jacobi, a fierce hater of injustice in any form, was appalled at the casual attitude that doctors and parents of his day displayed toward the ills of the young.

Hospitalized children then had only an off chance of surviving; in some places, the mortality reached

"It's your bill, Doctor. It's making me ill."

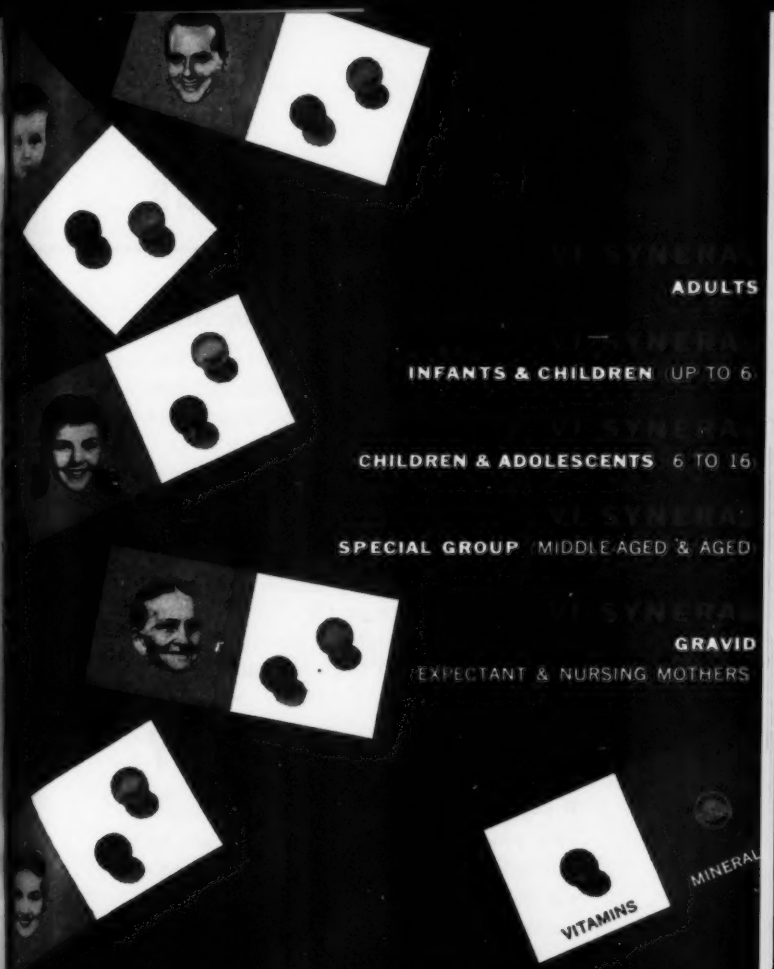
100 per cent. But the germ-ridden wards were always full. Society do-gooders regularly "rescued" children from the slums and put on elegant charity balls to pay for their hospitalization. Some of these great ladies ran their own hospitals or orphanages with whims of iron, casually countermanding the orders of physicians and bouncing any doctor who protested.

The public loved it. "Who," rhapsodized one newspaper, "could think unmoved of these tender ones, rescued, perhaps, from the tyranny of a drunken father or from the breast of an intemperate mother?"

Jacobi thought of the children and protested that they were being condemned to death—that they stood a better chance of survival in the slums. Outraged, the Nursery and Children's Hospital fired him for cruelty. He'd been unkind enough to halt the distribution of contaminated candy in the wards.

The fierce intensity of the little immigrant with the big beard won him a hearing among physicians. Within a few years of his arrival, he was writing original articles for the New York Journal of Medicine—and they were truly original.

In 1858 the New York Medical College created a professorship for Jacobi, and pediatrics was born. He introduced the system of placing dependent children in foster homes. His fame became statewide, then nationwide. In 1880 the A.M.A., which had long looked at Jacobi with a jaundiced eye, established a



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A Retired Woman Physician:

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"Total permanent disability obliged me to retire at 61 years of age five years ago. Having dependents I am unable to contribute to the Foundation as are physicians in active practice, yet I am aware of the truth of Dr. Cline's statements and the weight of his conclusions and send herewith a small check."

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If you have missed doing your part—why not send your contribution today. All gifts can be earmarked for any one of the approved medical schools—and the money is income-tax deductible. Send your check now.

American Medical Education Foundation

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section on pediatrics and named him its first head.

Jacobi married Dr. Mary Putnam in 1873. She, too, was a pioneer—the first woman to enter (after an incredible struggle) the famed *Ecole de Médicine* in Paris. Short, dumpy, not very attractive, but determined and intelligent, she achieved other notable firsts: Working with Elizabeth Blackwell in the newly established Women's Medical College of New York, she was one of the first women medical teachers. With her husband, she helped found New York's Mount Sinai Hospital.

She was 30, Jacobi 42, when they married. Miss Truax has essayed to describe their life together, their impact on each other. But, unfortunately, she has let herself become distracted by unimportant irrelevant material. And she uses the irritating "fictionalized" method so dear to popular biographers. The consequence is a great deal of tedious description of political and economic issues of the day. Some of her dialogue is as improbable as anything produced since Horatio Alger.

In short, the warmth, the spontaneity, the meaningfulness of real life are sadly missing from large sections of the book. One understands that these two people meant much to each other and found inspiration in each other, but never *why* or *how*. END

"Worrying over your bad heart has caused stomach ulcers, giving you indigestion resulting in nervousness, which is responsible for loss of weight due to worrying over your bad heart."

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How well does competition work in the steel business?

. . . the U.S.A. shows an 83.4% gain in steel output between 1939 and 1950. The rest of the world shows an 0.8% loss.

. . . In 1939, the U.S.A. under "competition" made ⅓ of all the world's steel. Today we produce half—all with only 6% of the people in the world.

. . . Steel workers under "competition" gained in jobs, too. There were 449 thousand jobs in 1939. Today—637 thousand.

The steel industry is just one example of what all of us can expect under a free competitive system. Ours is the security millions of people in the world dream of when they embrace such dead-ends as "planned economies".

Look around and see what happens when people hand their jobs and their factories over to the government. Or have them taken by law. Or by force. Name it what you will—"communism", "nationalization", "socialism", "regimentation"—it is a one-way street and no turning back. By then people no longer own government. Government owns the people.

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THE COMPETITIVE SYSTEM DELIVERS THE MOST TO THE GREATEST NUMBER OF PEOPLE

I Streamlined My Practice—Alas!

[*Continued from* 79]

differential diagnosis was an open discussion; my prescriptions were typewritten in English, with the medicine's physiological and pharmacological action carefully explained. I even told patients that a cough medicine need not be discarded once the cough is gone, but can be used by other members of the family.

I told mere neurotics how silly it was for them to come to a doctor. And I told people with incurable disease exactly what was bound to happen. Yet it was a curious thing—the more I invited their confidence, the less confident they became. Patients left me in droves.

Then there was the matter of fees. I'd placed signs all over the office, inviting the patient to talk it over. At the start of each consultation, I would warn him that my price for just listening would be three bucks. Then I'd explain that if he dared lean his nice warm back against my fluoroscopic table, I'd slap on an additional five-buck charge; and if perchance I should find him in need of a meningio-ureteral anastomosis, the damage would be $13.50.

Next, I invited him to tell me all about his bank account, his mortgages, and such. I reassured him by explaining that if he didn't have the wherewithal, he could make arrangements with the Small Loan Association—which, by coincidence, had a branch office in my reception room.

Thus I made every effort to convince him that money played no part whatsoever in our relationship. Sometimes, at about this point in the consultation, I would ask him what his trouble was—double or nothing.

Doctor's Diagnosis

It occurred to me one day that my own appearance could also stand streamlining. Looking into the mirror, I saw a balding, flabby, sallow-cheeked apparition. Where were the the bright eyes, the pink cheeks that radiate good health and inspire a patient's confidence? Could anyone believe this sick-looking beast could restore him to health?

I betook myself to a gym and started on exercises. I worked myself up from dumbbells to rowing machines, from parallel bars to handball, from track to water polo. I gave up smoking, drinking, eating after supper, and staying up late. Eventually I got myself into superb shape physically.

The only trouble was, my disposition got worse every day. Finally I fractured an ankle and was reduced to playing chess. Now the shoulders of my suits have to be padded again, but my disposition is improved. And my patients seem to

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2 Therapeutic amounts of rutin and ascorbic acid, to combat related capillary weakness effectively. Damaging retinal hemorrhage often results from excessive capillary fragility and associated abnormal cholesterol deposits.

A daily dose of 6 tablets provides:			
Choline	1 Gm.	Pyridoxine HCl	4 mg.
Inositol	1 Gm.	Rutin	150 mg.
dl-Methionine	500 mg.	Ascorbic Acid	75 mg.

VASCUTUM is another Schenley Laboratories contribution marking a distinct advance in the management of interrelated degenerative diseases clinically prominent in the middle-aged and elderly.

SUPPLIED in bottles containing 100 tablets.

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like it: After one look at me, they realize they aren't so badly off after all.

Practice-Builder

One of the questions I had long asked myself was, "Why am I not getting more consultations?" After all, I had as much free time on my hands as other specialists. The answer seemed obvious: I needed to do more entertaining. So I began to entertain every professor and specialist I knew—and wound up by sending them all *my* cases.

Well, how about entertaining general practitioners? I tried it. But each G.P. I entertained felt he had to reciprocate—and after that I had to entertain him right back. I had a wonderful time, but unfortunately there was no time left for practicing medicine.

So I switched to entertaining patients, prospective patients, and prospective prospectives. I took no chances. Anyone who could possibly become ill was invited to my house. Ninety-six cases of Scotch later, I discovered that the net effect on my practice was minus 2 per cent. It seems that ladies who knew my wife couldn't bear to let *me* touch their bellies, and men whose wives *I* knew would never explain how they'd got that aching back. (I know all this sounds unbelievable. That's what the tax collector told me, too.)

Then I remembered psychosomatic medicine. After all, wasn't 99 per cent of all illness mental? Perhaps I'd tried to explain symptoms from too much of an organic standpoint. Now, instead of prescribing vitamins, I began to prescribe letting down hair. I installed a couch, indirect lighting, and a tape recorder. I even bought a special pad to doodle on while listening.

Patients seemed to like this approach. We talked and talked and talked. When we were finished, the patient always knew all about my troubles, my children, and my maid. I began to feel better than I'd felt in months. But I felt obliged to stop when my wife asked me how so many people knew of her mole.

Complete Collapse

At about this point, I ran out of streamlining ideas. I realized I was a failure. My car was now wretchedly undistinguished. My office was stripped of fancy gadgets and utterly nondescript. My physicial condition was terrible, and I'd begun to entertain no one but my unquestioning family. I was so exhausted that I had to be just myself.

And then it happened. My practice came back. My patients were comfortable with me and I was comfortable with them. They were getting the best medical care I could give them, and things even looked better in the bank.

Well, that's my story. I don't know if there's a moral to it, but does anyone want some good practice-building ideas—cheap? END

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Why doesn't medicine crack down on physicians who are guilty of malpractice? This hot question has attracted the fiery pen of Philip Wylie, author of the book "Generation of Vipers." We print his views here (condensed from Redbook*) in the belief that they will stir our readers to analytical thought and comment. Excerpts from such comment as we receive will appear in a later issue.

The Doctors' Conspiracy of Silence

By Philip Wylie

● This article is going to raise hell. It's possible this article will raise enough hell to do some good, which is the reason for publishing it. But it's absolutely certain that numbers of important irate men will claim it will have done nothing but harm.

It's an article about an evil among medical men—an evil of which most of them are fully aware—an evil which some of them, today, are trying to correct in a rather gingerly way. It's an article designed to show that the "noble art" of Medicine is too much practiced as a *business* in which life and death are mere commodities—and that the medical profession, which is supposed to keep its own house clean, too often looks the other way when you and I and our loved ones suffer or even die because of medical greed, needless medical stupidity, or plain medical crime.

Before I go into gory and gruesome detail, I want to make one thing entirely plain:

There is no profession I admire more than Medicine. Laziness in school, plus, perhaps a special aptitude for writing, kept me from becoming a doctor, myself. More than once, by brains, skill and courage, medical men have saved my life and the lives of most of those I most love. The debt I owe Medicine and medical men cannot be paid in money, ever. And today, as through my entire adult life, the largest numbers of my closest friends and acquaintances are physicians.

However, it is the very intensity of my respect toward Medicine which makes me, at long last, unable to endure what I regard as a vast professional "sin" for which

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*By special arrangement with Redbook Magazine, which published the original in its March, 1952, issue.

nearly all doctors somewhat share the guilt.

The "sin" is this:

Too often, much too often, people are expensively "treated," not to cure them, but merely to make money for a doctor. Much too often, you or I (or some member of our families) get operated on not because the operation is needed, but because the surgeon wants a new car.

Too often, some of us are taken into operating rooms and cut open by doctors who, in the sure judgment of qualified men, are unfit to attempt such surgery. And much, much too often, some of us, not knowing how to tell a good doctor from a poor one or any way to find out the difference, fall into the hands of men with medical degrees who are, actually, criminals, psychopaths, sadists, demented by senility, dope addicts, and so on.

The results are needless pain and suffering, scarring, maiming, mutilation and death.

The Real Sin

All that, of course, is wrong and terrible. *But the real wrong lies in the fact that the body of physicians and surgeons, who are best fitted to judge one another, usually maintain an utter silence about all such wanton ravishment of the public.*

The crimes I shall protest here are limited to a minority of doctors and the surgeons. Perhaps to 1 per cent. Perhaps to 10 per cent. Nobody knows the figures. But I think the point is obvious: where life and death, health and invalidism, are the stake, even one one-hundredth of 1 per cent of known crime and malpractice is a public and a professional disgrace. And it's a very long-standing disgrace.

What sort of thing do I mean? Listen.

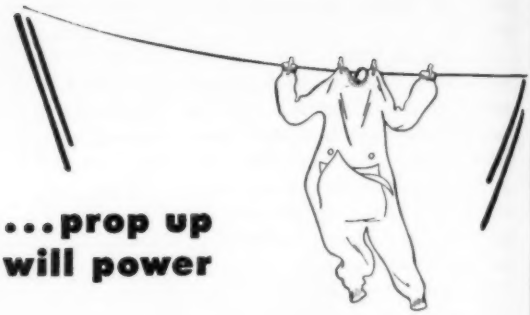
After her fourth child was delivered—at home—the woman began to bleed. Her doctor raised the foot of her bed and packed her with cotton. The bleeding continued. In a hospital, even in those days, it might have been stopped by instruments. But her doctor decided that he could "pull her through" at home. He didn't. And that's how my mother died.

Father had wanted to call an ambulance. The doctor had been reluctant. He wasn't "up" on "modern" methods; hospitalization meant he would lose the case to another man. So my mother died—perhaps needlessly.

Listen, again.

The child had a rigid, swollen abdomen and suffered terrible pain. Day after day his fever rose, his agony increased. Every day, the osteopathic physician who was treating him kneaded the swollen belly in which an appendix had long since ruptured. On the fourth day, looking at the taut, yellow abdomen, the osteopath admitted he was "stumped" and suggested calling a surgeon.

The boy spent many months in



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the hospital after that, first with peritonitis, then with general blood poisoning, and afterward with a hernia operation. He was saved by a brilliant surgeon—to the astonishment of the entire medical profession (for that was long before the day of sulfas, molds, and miracle drugs). But if the osteopath had known better, that kid would have been spared an interminable, an unforgettable ordeal, as well as two years of debility and the lost schooling.

I ought to know. I was the kid.

Today, most osteopaths know better. But do they all? And do all chiropractors know better? All *naturopaths?*

Also, no!

Or, listen to this:

Not many years ago, a doctor I knew was asked to serve as anesthetist by a colleague. The operation was a curettage, technically a simple one. But the surgeon in this case went to work with clumsy vigor, alarming my doctor-friend immediately. Soon, the surgeon rammed his curette clear through the wall of the uterus, yanked it out with an oath—and brought with it a loop of intestine. He then made a botchy effort to patch up the damage. But his patient died of blood-poisoning. Before she died, she told my doctor-friend that the operation had never been a medically necessary curettage, but merely an abortion. My friend had her sign a statement to that effect.

It might be presumed by any layman that the doctor I knew would instantly have used that signed statement as a means of seeing to it that the incompetent surgeon was disbarred from medicine or, at least, restrained from operating, ever again. (The man already had a long record of high mortality among his patients and a reputation as a "butcher.")

What actually did happen? The doctor I know used the signed statement of actual medical crime as a means to stop that particular surgeon from doing any further surgery in the same hospital. That was all! He applied to the criminal surgeon a little polite blackmail. The surgeon, thereafter, simply shifted his operating base to another hospital, where his reputation for butchery increased and his mortality rate stayed far above the norm. Many other doctors in the area knew the

"Somebody better be <u>real</u> sick!"

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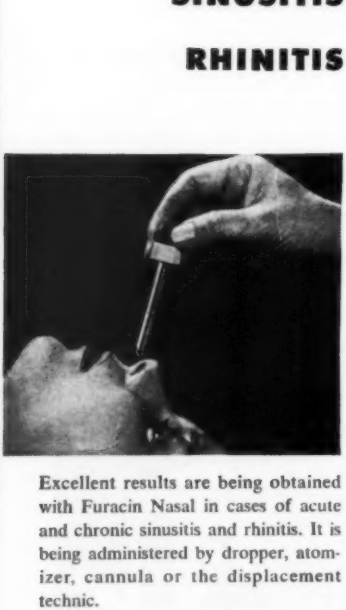

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*Thornell, W. C.: Arch. Otolaryng. 52:96 (July) 1950.

Literature on request

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facts. But nobody took any further action. On the contrary, the surgeon who had performed the abortion that killed the woman was eventually elected president of his medical society!

Surgeons will argue that such a particular ghastly bungle is a special case. True. But why wasn't anything done about it? Why was the totally inept surgeon allowed to go on operating—and even elected head of his society? How many other such gruesome "special cases" has he left behind in his long record of manifest incompetence? "*Special cases*"—under tombstones, today? And how many other surgeons, in big cities, in towns, in hamlets, are adding up similar totals of gross error, at the cost of public suffering and death, and from whom the public has no adequate protection?

Inside Information

I have given, so far, of course, only special instances of disastrous mispractice that are known to me. Each one, by itself, is an isolated event. But it is not my personal observation which convinces me beyond any doubt that such events everywhere occur hundreds of times. It is, rather, the talk of really able doctors, all of them aroused to indignation.

There are two other sorts of persons who will add, confidentially, a world of horrors to anybody's list: internes and nurses. Medical students are often acute judges of incompetence. Experienced nurses, especially operating-room nurses, are even more acute. To have one such as a confidante (and I've had a dozen) is to learn a great deal about the frequent valor and magnificence of medical men—and a great deal, also, about their all-too-frequent gross abuse of the meaning and purpose of their profession.

'Privileges' and 'Ethics'

Long ago, I learned, too, why it is that such abuses, and others yet to be discussed, can continue, year after year, without restraint or adequate action of any kind:

The medical profession is "*privileged.*" It has "*ethics.*" It has what it regards as "*special knowledge.*" For these reasons it deems itself alone qualified to define and to police its own behavior.

Whether or not doctors have the sole legal right to be judges of themselves is not exactly open to question; by and large, they do have it. Whether or not they should have so much authority, is a different question. And part of its answer depends upon how well they "police" themselves. It is my contention that they do a wretched job of it.

What has actually happened is that the doctors have long used their special (and necessary) privileges as a shroud to hide the "skeletons in their closets." They bring charges against each other rarely. As groups and societies, they rarely disbar each other. And what they complain

about in private, they refuse to mention in public.

As individuals, they have alibis, of course. If they make charges, they must prove them. Since medical proof is hard to obtain, moreover, if they make charges, they are wide open to damage suits. Critical doctors will have reason to fear that some honest error of their own may later be turned into the basis for a countersmear. One doctor, alone, obviously cannot stand against the traditional silence of the lot.

A Physician-Crusader

A good many years ago, a brilliant surgeon tried to take just such a stand. He was the late Norman Barnesby, another of my many close doctor-friends. His skill, in the Westchester (New York) area where he practiced, was widely renowned. Some of the most powerful and richest men and women of America were his patients. Dr. Barnesby became appalled at the inept, ignorant, slovenly, obsolete, callous and sometimes downright wicked "surgery" which he saw practiced by other men—some as "famed" as he.

So he wrote about what he had seen. His book was called "Medical Chaos and Crime." The general public paid it little heed. But it created a tremendous furor among doctors. The book—a solid listing of such reports as have been entered here (and by a surgeon who knew every technical detail of each case)—was intended to initiate many reforms in hospital and nursing procedure, in operating-room techniques, in the standards for examining surgeons, in training, and in other areas of qualified medical procedure.

A Physician Persecuted

Here and there, Dr. Barnesby told me many years afterward, a few changes actually were made as a result of his book. But in general, this inside "exposé" of the abuse of the public by medical men was regarded as a sort of treason. Barnesby was lambasted in professional journals from one end of the nation to the other. His own practice and private life were given intense scrutiny by doctors wishing to discredit him. Efforts were made by doctors to have him thrown out of the profession or expelled from the hospitals where he operated. His reaction was to write a second book, which added to the cases and the accusations of the first one.

From then on he had no peace. Many of his own colleagues became his sworn enemies. Suspicion was cast on his motives, his competence, his surgical work, his entire way of life. In the course of time he developed a tremor, probably owing to the stresses under which he was obliged to work. He quit surgery, and until his retirement, practiced industrial medicine as the doctor engaged by a large New York bank.

There is nothing unique in this story of Norman Barnesby. Many

other medical men, on a national as well as a local scale, have tried to reform their profession. But they have gone down in defeat and even ruin by the near-conspiratorial efforts of doctors themselves. Most physicians prefer to remain silent. In that fashion the enormous "privilege" which good doctors truly require is used to hide the misdeeds of the chiselers, quacks, crooks, and plain maniacs.

Perhaps all doctors together—the responsible, honest ones—cannot make the rest modernize their minds and methods. But certainly they can be held more accountable in many ways for their profession. If one of their members regularly is doling out useless but expensive treatment for gain alone, they usually know it. Even when, as I have said, the medical "crime" in question is merely excessive stupidity, ignorance and incompetence, if it goes on, *it should be exposed, not protected,* by physicians. Today doctors do nothing. They should *raise hell!* Instead, where individual capability is questionable, even as a group doctors are noticeably disinclined to accept responsibility for culpable practitioners.

Around doctors hangs the sacred shawl of Privilege. And to keep their privileges sacrosanct, they seem willing and often anxious to conceal their manifold and multifarious abuses of their rights—and ours. Furthermore, in every case I've mentioned I can tell you what happened. But I cannot prove guilt

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against any doctor. That proof could be furnished only in certain instances and only by other physicians and surgeons—*and they won't give the proof,* even when, in private, they had firmly, completely, and horrifiedly described the facts.

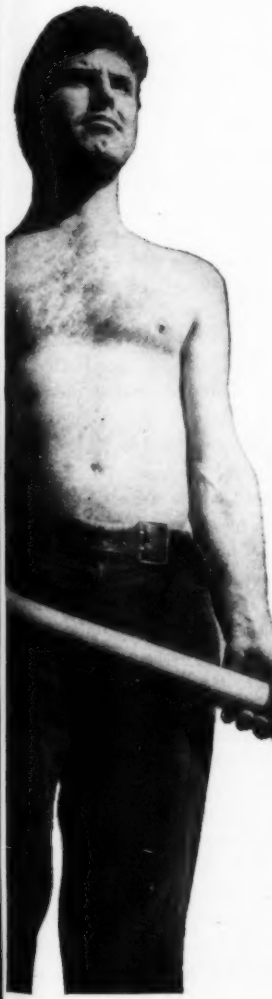
What medicine needs, I think, is a federal policing board made up of lawyer-doctors; it needs a new set of laws; it needs uniform state laws. It also needs the power and the will to hunt down and limit or end, as need be, the practice of every doctor who, for whatever cause, is unfit to do his job; or who does jobs for money instead of for human welfare; or who commits crimes in connection with and in the name of the medical profession.

I have two points to add, before you enter into any campaign to "purge" the medics. I am not convinced, first of all, that "socialization" is the answer to any of these problems. *More* individual responsibility, not less, is desperately needed in the doctor's own office and elsewhere—not only in public institutions, the "snake pits," the charity hospitals, and hospitals for the aged, but in the private institutions as well.

My other point is this:

In criticizing the doctors, we must never forget that most of them measure up closely to the tremendous ideal we see in our mind's eye. Some of them are unskilled, that is true; many are still using antiquated methods and outmoded practices for treating their patients. And too many

even the hardiest skin...



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1. Underwood & Gaul: J. A. M. A., 130:249, 1946.
2. Goodman, Herman: J. A. M. A., 129:707, 1945.

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of them are using their profession as a gainful business to further their own ends rather than to benefit mankind.

We must remember, on the other hand, that doctors are busy people. They hate committees. They hate litigation. They hate to interfere with each other, lest they be interfered with. Most of them do a magnificent job.

What, then, do we still want of them? If we strongly feel that we should be protected by every doctor, individually or in groups, from the terrifying minority who are a real threat to those of us who place our lives and bodies willingly in their hands, we should ask—no, *demand*—that they be still better, as people, as citizens, and as members of a very special and wonderful group of men. For I have no doubt that, among all human beings, on the Great Ledger of Sacrifice, Integrity, and Absence of Hypocrisy, doctors stand first—even, in my opinion, above clergymen! That does not prevent me, however, from claiming that their studied avoidance of a certain kind of responsibility for themselves amounts to a moral racket.

Ours is a rugged request. But because thousands of innocent men, women, and children suffer agonies, die, or bear the burden of fantastic cost in money and privation, as much as I admire doctors, I stand steadfast against a racket which is beneath men who occasionally are privileged to reach out and touch the hand of God. END

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Anti-Vivisectionists On the Run

[*Continued from* 76]

coveries. Anti-vivisectionists attacked the bill as an invasion of private property, as a step toward socialism, as unconstitutional, and as an extra financial burden on taxpayers.

Mrs. Marion Parks Grey, president of the Legion Against Vivisection, took doctors to task for their present-day attitude. In her grandfather's day, said Mrs. Grey, "the medical profession ranked with the ministry in prestige; it was not a political racket as it is today . . . Doctors [have] put God in a test tube and have reduced the Ten Commandments to a chemical formula, and still they can't cure the common cold."

Medical men at the hearing raised their eyebrows when one of their colleagues, Dr. Millicent Morden of Brooklyn, actually testified against the bill. Here, in brief—and without a single emendation—is a sample of her argument: "I belong to a group . . . who are experimenting on disease because they have found that experimentation on animals does not work . . . We know about cancer, and if the millions thrown into animal experimentation had been given to help our soil, we wouldn't today be suffering from these things. We all know the cause and cure of cancer, but we are not allowed to let it out. Why? Because there is so much money in finding and searching . . ."

Perhaps understandably, the legislators weren't swayed by such arguments. Three weeks after the hearing, they passed the bill, giving it a healthy margin of votes in each house.

There were still problems ahead. Many humane societies threatened to close their shelters and make the cities set up their own. Opponents threatened to contest the bill's constitutionality.

But it was a whopping victory for doctors. They had proved that determined opposition could defeat the anti-vivisectionist in his own stronghold. Medical men and other scientists, laying plans for similar campaigns in Pennsylvania, Massachusetts, Washington, D.C., and elsewhere, took new hope. END

"Was I ever an old butter-fingers in surgery this morning!"

Fee Splitting: Who Does It—and Why

[*Continued from* 71]

he may or may not have helped at the operation; he visited the patient daily. The probability is that his time spent on the case totals several *times* four hours.

"Rule number one of the Principles of Financial Relations of the American College of Surgeons says that 'Each doctor who participates in the care of a patient is entitled to compensation from the patient, commensurate with the services rendered.' So if the patient was told the operation would cost $500, how much does each doctor get?

"Does the G.P., for example, receive a 'commensurate' fee?

"He does not.

"The surgeon is not allowed to protect the family doctor by means of a combined bill because the principles say that 'Combined statements should be avoided, as they may constitute subterfuges for fee splitting.' Result: The surgeon pockets the $500."

Many medical men, while sympathizing with the general practitioner who recounted this case, would not agree with his apparent conclusion. They would not say that a combined bill—or split fee—is necessarily the right answer. Here is how they might state their argument:

There is probably some justice in

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the view that surgeons' fees are disproportionately large, considering the time and training and judgment involved in the less dramatic medical services. But practitioners who maintain this I-work-my-fingers-to-the-bone-and-what-do-I-get? attitude and who therefore attempt to justify the split fee or the combined bill overlook two important facts:

What's Surgery Worth?

1. They fail to consider the risk in doing surgery. It is the surgeon who shoulders the blame when anything goes wrong, whether or not it is his fault. Who can say how much this responsibility is worth?

2. Like other prices in a free economy, medical fees are established essentially by the law of supply and demand. In the operating room, as in Hollywood and elsewhere, emotion rather than logic may determine demand—and hence price. This is too bad, perhaps, but it is inherent in the economic system that doctors are eager to protect.

The essence of capitalism is that goods and services should compete freely with one another in the open market. Would medical men condone secret price rigging aimed at adjusting the rewards of everyone in society whose compensation is out of line with somebody's evaluation of his usefulness? Of course not.

Well, then, it may be asked, what about splitting fees in an effort to bring justice into the medical fee system? Is the basic concept of fee splitting any different from that of secret price rigging? END

Doctors Take to TV

[*Continued from* 88]

feature of this health program is that real doctors appear, not actors with crepe hair and little black satchels."

When "Here's to Your Health" first hit the TV channels (on Feb. 10, 1952), it had been more than a year in the making.

The concept of popular mass health education through TV came to the New York County medical society from Dr. Lester L. Coleman. Dr. Coleman, a Manhattan otolaryngologist, had long been disturbed by the hysterical, usually unfounded fears that some patients brought to his office. Doctors, he felt, should not wait for the phobia-ridden patient; rather, they should attempt to "intercept" him by means of widely disseminated medical information.

When the era of coaxial-cable TV set in, Coleman decided this was the ideal medium for the job. But the medical profession, he realized, would have to offer highly polished, really professional productions—especially if it were to vie for the choicest evening hours.

Professional writers, directors, and producers would be needed. How could a county medical society, even a large one, launch such a high-budget show? Dr. Coleman's answer: Get a commercial sponsor.

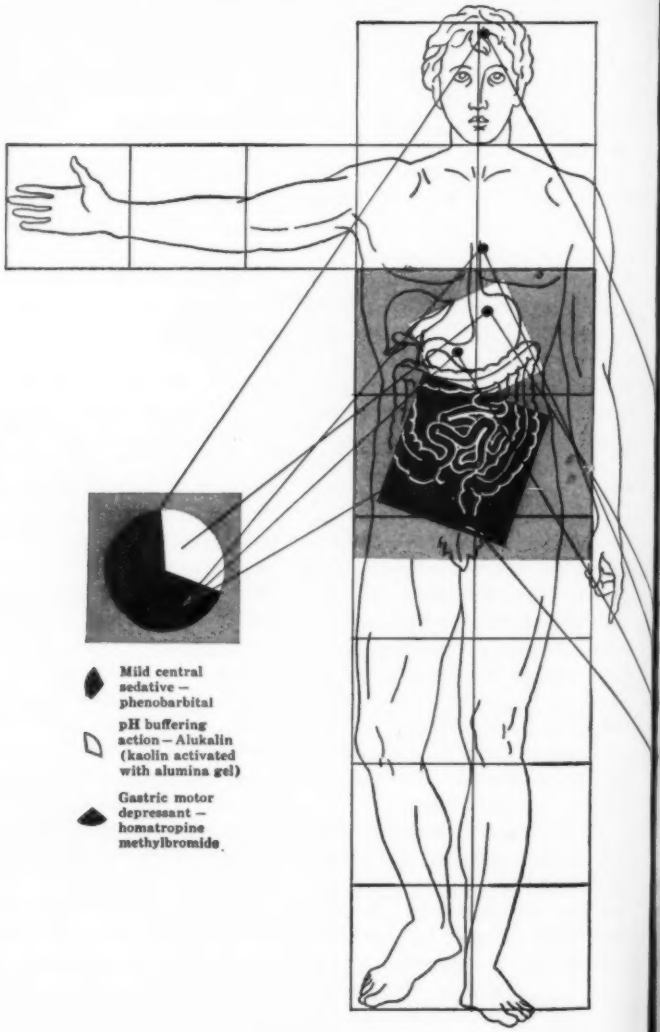
Such ideas were not warmly received by some medical men. When Coleman introduced his TV blueprint to the county society, there were plenty of questions to be answered: Would it be unethical for physicians to appear on such a "popular" program? Would the venture be undignified? Who'd sponsor it?

Indeed, back in the winter of 1950 it looked as though there were too many questions to ever be answered. More than once it seemed that the TV project would die a-borning. But thanks to yeoman's service by Dr. Kenneth M. Lewis, then president of the New York society, and Reed B. Dawson, the society's legal counsel, the idea gained momentum.

Finally, after many planning sessions, the county membership voted approval of the projected health series. A contract, naming Dr. Coleman as physician-producer, was drawn up. In giving the medical society "immediate and complete control" over the programs, the twenty-page contract goes to remarkable lengths.

For example, the society has categorically reserved control "over the type of program to be presented, over the choice of commercial sponsor, over the commercial announcements to be made, over the content of the remarks of the moderator of the program, over the choice of physicians to appear on the program, over the choice of questions to be answered, over all

SPECIALIZING *in* SPASM



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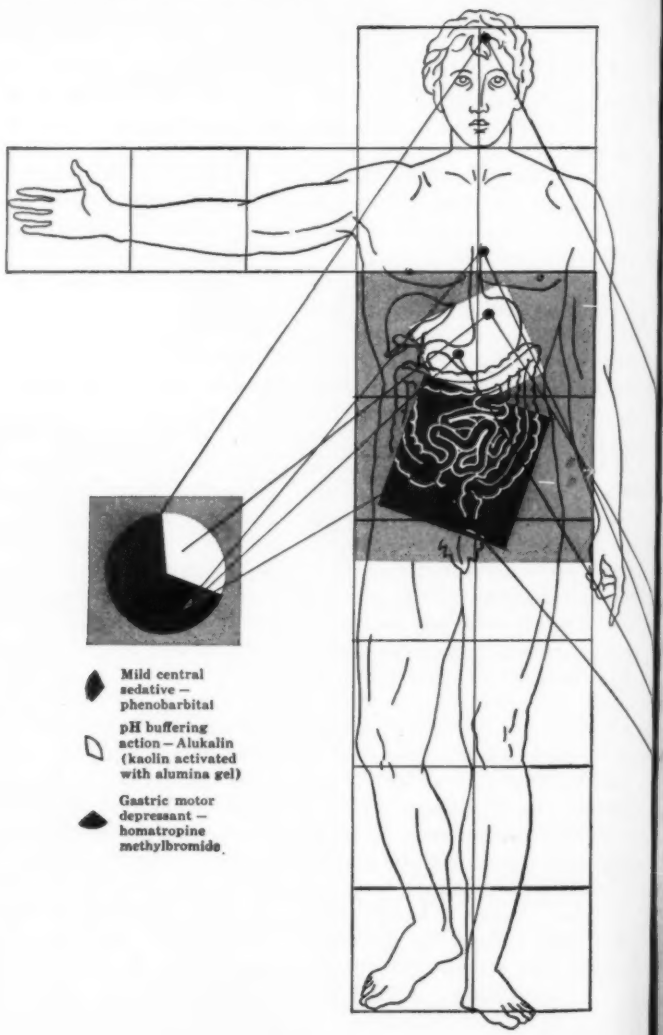
Gastric motor depressant — homatropine methylbromide

SPECIALIZING *in* SPASM



Mild central sedative — phenobarbital

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I'm Glad I Left General Practice

A contented convert to the commercial life looks back on his G.P. days

● A year ago, a cardiac infarct interrupted my busy general practice for good and catapulted me into that maligned field, commercial medicine. My cardiologist's verdict had been final: no more obstetrics or surgery (40 per cent of my income), no more night work.

My colleagues had of course volunteered all sorts of suggestions:

"How about an easy specialty?" Not a chance. At 38, and with a family, I couldn't afford time to take the graduate training.

"Industrial medicine?" No. That would mean more patients than I was already seeing.

"Military or other Government service?" These, too, were out because of physical requirements.

But there *was* one last disparaging tip: "Of course you can always go commercial."

Well, I *did* "go commercial." Interviewed by a large drug firm, I learned not only that I could pass their physical but was eligible for their group insurance plan. I snapped up their offer of a position as regional medical director.

Today, comparing my present medical life with my former general-practice existence, I wonder why I didn't make the change long ago.

Not that I didn't average pretty well in general practice. Four years in the Army Medical Corps had shaken most of the stardust from my eyes when I opened an office in my home town—a relatively high-income suburb of a large city. I got off to a good start with staff appointments in some "closed" hospitals, a school examining position, and part-time work at a nearby Air Force base.

By 1950, after only four years in practice, my gross income was $15,500, my net a little over $10,000. (Of course my standard of living was far below that of my physician-father during the first quarter of the century, though his fees and case load were much the same as mine.)

My chief complaint against general practice—aside from long, irregular hours and too many non-

---

**Because he still lives in the same town in which he formerly practiced, the author prefers to remain anonymous.*

paying telephone visits—was this simple fact: I was being cut off increasingly from the kind of medicine I wanted to practice.

Without warning, for example, I had found myself barred from the operating rooms of my hospitals because I was neither specialty-board certified nor a house staffer. For a simple appendectomy, thereafter, an interne might be first assist while I, as referring physician, had to watch progress through a porthole in the door. This despite the fact that my surgical training was above average and the Army had thought me good enough to be chief of surgery in a 200-bed hospital.

I couldn't perform tonsillectomies, cystoscopies, D & C's, or even simple fracture procedures. All surgery was denied me unless I did it in my office or in an unrecognized hospital. It wasn't hard, therefore, to see the handwriting on the wall: Soon the delivery rooms, X-ray rooms, and laboratories might also be beyond my reach.

I'm one who believes that a good G.P. can handle without help 85 per cent of the patients he sees. But consider my referral rate for 1950. It was 32 per cent—just double that of 1946, my first year in practice. Was I to grow older, getting more and more experience, only to serve as a hospital admitting man or general referral clerk?

Today, thanks to the change of life brought about by a little cardiac insufficiency, I needn't worry about these problems any more. My new duties require me to visit teaching hospitals, to initiate and supervise clinical trials of new pharmaceuticals, to conduct training classes for sales representatives, to supervise a camera crew making educational movie shorts, and to handle some medical correspondence and advertising. I travel about one week a month on a very liberal expense account.

My work is stimulating without being overly tiring. By frequent contact with leading investigators, I keep abreast of basic scientific advances. Almost daily I lunch with some outstanding clinician. My teaching program, though not a heavy one, allows me the stimulus of sharing what I've learned with the students.

The final payoff comes at the end of the afternoon. When 5 o'clock

"You're getting along as well as can be expected—if one doesn't expect too much."

strikes, I shut my door and stop work for the day.

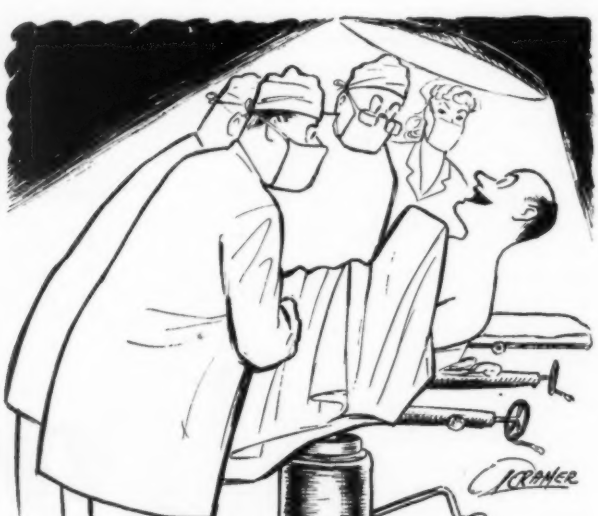
Now, too, I spend my weekends at home. My wife and the children are no longer strangers. I can count on finishing a round of golf. My cellar wood-working shop gives me many hours of relaxing, constructive pleasure with tools I'd bought three years ago and never used. What's more, my EKG tracings show continued improvement, and my sleep is deep.

My salary for this pleasant work started at $10,000, has already been raised to $11,000. Further annual raises will continue up to $15,000, when stock and bonus plans begin to operate.

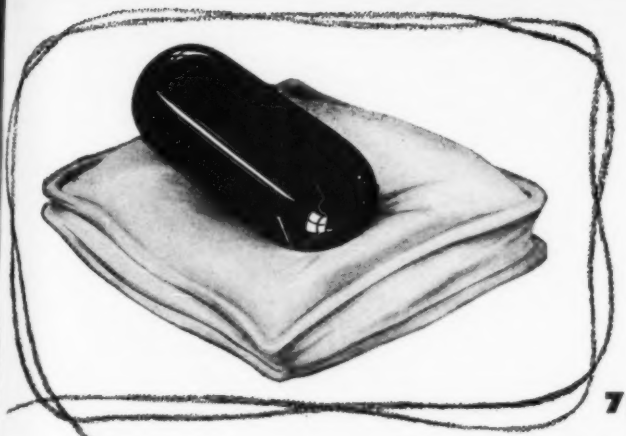
I have a $20,000 group life insurance policy; a liberal health, accident, and disability policy; and at 65 I'll retire on a pension that's 44 per cent of my median salary. All of which costs me just $13.47 a month.

I now work 35 hours a week to earn what took me 70 to 80 hours in general practice. My work hour, in other words, yields me $6 instead of $3.20.

"Commercial" it may be. But my family, my coronaries, and I—we love it! END



"Just a reminder, Doctor. All my money is hidden. And where only I can find it!"



7½ gr.

7½ gr. (0.5 Gm.) *BLUE* CAPSULES CHLORAL HYDRATE—*Fellows*

•DESIRABLE SLEEP lasting from five to eight hours, usually free from undesirable after-effects. Pulse and respiration are slowed in the same manner as in normal sleep. Reflexes are not abolished and the patient can be readily aroused.[2] "CHLORAL HYDRATE produces a normal type of sleep, and is rarely followed by 'hangover'."[1]

Dosage: One to two 7½ gr., or two to four 3¾ gr. capsules at bedtime.

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•DAYTIME SEDATION for the patient who needs daytime sedation and relaxation with complete comfort.

Dosage: One 3¾ gr. capsule three times a day, after meals.

3¾ gr.

EXCRETION — Rapid and complete, therefore no depressant after-effects.[3, 4]

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The Newsvane

Are Kentucky Meetings More Fascinating?

Evidence of the degree to which attendance at medical meetings varies in different parts of the country appears in some statistics just compiled by the American Cancer Society. The figures reflect reports received from six state medical societies on the attendance at their annual meetings in 1951.

According to the statistics, Kentucky's attendance record is twice as heavy as Illinois'. Out of a total Kentucky membership of 1,848, a whopping 846 doctors—or 46 per cent—took part in the last state medical convention. In Illinois, only 22 per cent of the total membership showed up.

Here are the percentages in the four other states surveyed: Colorado, 42; Oregon, 36; Massachusetts, 29; Iowa, 27.

St. Louis Leery of 'Health Centers'

Should private therapists' offices or health centers offering diathermy, hydrotherapy, douches, massages, and infra-red and ultra-violet treatment be approved by medical societies?

Emphatically not, says a special committee of the St. Louis Medical Society. Here is the committee's reasoning:

Therapists are examined and licensed by the American Registry of Physical Therapists, whose governing board consists of physicians. They are then qualified to practice —but only and always under the supervision of qualified physicians.

In recommending that the society withhold its approval of the private practice of therapy, the St. Louis committee points out that the therapists' code of ethics clearly states that under no circumstances shall they "on their own initiative treat patients or operate an independent office."

Make M.D.'s Pay Hospital Losses? No, Says Expert

Far from losing money, a hospital's laboratory, X-ray, and anesthesia services—handled on an independent practice basis—should bring in a profit of 10 to 15 per cent. So said Dr. Malcolm T. MacEachern, director of professional relations of the American Hospital Association, when a harried hospital board asked him for advice.

The board had been thinking of

assessing physicians a flat fee of eight or ten dollars for each of their patients admitted to the hospital. This, some members felt, might avert the need for increased hospital rates and other charges to patients.

When asked for his expert opinion, however, Dr. MacEachern thought the plan a poor one. It would not, he maintained, "promote good professional relations." And the end result would be a passing on of the charge "to the patient by the physician."

Pointing out that the proposal might also have certain "legal implications," MacEachern recommended that charges to patients be boosted instead. "Regardless of the plan of operation," he said, "laboratory, X-ray and anesthesia should be self-supporting unless a large amount of free work is being done."

Discuss Money Matters? Go Right Ahead

It is less embarrassing for a patient to discuss a bill with the doctor than with his secretary, says William H. Rustad, chairman of the Committee on Professional Relations of the San Francisco Medical Society. After all, he points out, the patient has, in all probability, already told his doctor a great many other personal things.

In 1951, Dr. Rustad's committee heard and considered fifty-seven complaints from doctors or patients. Most of those complaints "revolved around the usual question of fees." And on the basis of its experience, the committee concluded that a doctor's unwillingness to discuss money matters often gives the patient "the idea that he is being sloughed off, which incites a feeling of resentment toward the fee itself, its collection, and, finally, the doctor."

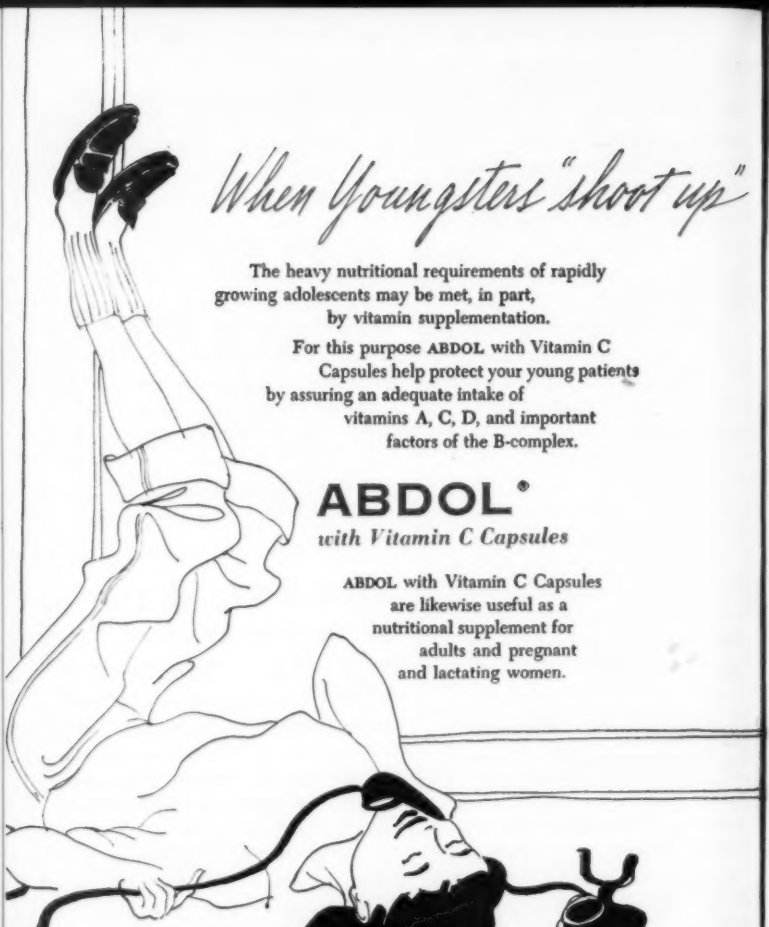
It's true that "busy doctors do not and cannot continue carrying around in their heads first-hand information about the status of the account of every one of their patients," says Rustad. But it is a "simple matter to have the patient's record placed before the doctor" so as to facilitate direct discussion of financial questions.

Advocates Keeping Lists Of 'Shopper' Patients

In line with recent suggestions that complaints against patients (as well as complaints against doctors) be turned over to grievance committees, Dr. George Schaefer of Queens County, Long Island, suggests that confidential lists of the "shopper" type of patient be kept in medical society offices.

"There are a few patients," he says, "who are never satisfied and who make life miserable for everyone . . . They 'use' a doctor until they have run up a bill and then rather than pay their bill, 'change' doctors under the guise of being dissatisfied with his services."

Without in any way advocating that the right of free choice of phy-



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MEDICAMENTA VERA

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sicians be curtailed, Schaefer believes that the names of such persons ought at least to be kept on file. And perhaps, he adds, it wouldn't hurt "if these patients knew such a record was being kept."

Says Industry Needs More Doctors and Nurses

Lack of doctors and nurses in industry may hamstring our rearmament program, says Dr. Howard A. Rusk, chief adviser on U.S. medical mobilization.

At the present time, he explains, some 2,000 physicians and 13,000 nurses are giving all or part of their time to industry; needed by 1953, however: just about twice as many doctors and half again the number of nurses. Meanwhile, the campaign for the development of better health services in plants is falling critically short of its goal.

Dr. Rusk endorses a proposal of the A.M.A. Council on Industrial Health for evening courses, sponsored by state and local medical societies, to indoctrinate doctors in the fundamentals of industrial medicine.

Doctors' Deductions for Entertainment Decried

Even though tax experts have called doctors' deductions for entertainment perfectly legal, some tax officials—and many laymen—still suspect them. This is what Sidney P. Hurwitz, a Milwaukee urologist, found out early this year when he was assessed $91.42 for deductions made on his 1946, 1947, and 1948 state income tax returns.

Howard A. Rusk
Plant doctors' night school

Fighting the levy before Wisconsin's board of tax appeals, Hurwitz has contended that specialists depend in part on the good will of G.P.'s for their practices. Entertainment expenses that may bring about referrals are therefore, he points out, both legitimate and necessary.

Newspaper accounts of the case in progress have brought out some interesting examples of lay hostility toward physicians who *dare* think of making a living. In one "letter to the editor," for example, a commentator says, among other things:

"This seems to prove that medicine is degenerating into just a very lucrative business . . . I for one

would hate to be referred to Dr. Quack instead of Dr. Ethics, just because Dr. Quack puts on a better floor show . . . From what I have been able to observe, a good M.D. needs to entertain no one except his own conscience."

Does Industrial Work Pay Off for the M.D.?

Supose you worked in a local industrial plant for an hour a day, five days a week. How much could you expect to make in the five-hour week? Answer: probably at least $62.50, or $12.50 an hour.

This, says a source close to the Industrial Medical Association, is about the minimum scale for hourly or part-time medical work in industrial plants. Though there are no standard fees for this type of work, the rate of payment is usually based on what a physician is apt to earn in private practice. Thus, the plant that pays $12.50 an hour figures that par for similar work in private practice would be two $5 house calls, or $10 an hour. The extra $2.50, in theory, covers the doctor's travel time to and from the plant.

For full-time work, salaries paid to M.D.'s by industry compare favorably with the average annual net incomes of private practitioners. Starting salary for a full-time medical man in an industrial plant is usually about $10,000 a year, according to the best available figures. Full-time medical supervisors are not, of course, often required in plants with fewer than 2,000 workers.

When an M.D. becomes a full-fledged industrial practitioner (usually with the title of medical director), he can expect an annual income of between $12,000 and $25,000 a year, a recent inquiry reveals. Men in this salary range usually are responsible for a comprehensive industrial medical program, and the $25,000 man may possibly supervise a staff of two or three other doctors as well.

What qualifications does a physician need in order to become a higher-bracket industrial-practice specialist? In the words of one prominent man in the field, he must be, first of all, a good, all-round surgeon. "And," adds this same source, "he also must have ability to handle the medical-legal phases of workmen's compensation; ability to be an expert witness in court and before industrial commissions; and special qualifications as an industrial relations leader."

Christian Scientist Loses Court Test

Can the religious conscience of a university student exempt him from a compulsory medical examination? Not if broader public interests would be endangered by such exemption, the Washington State Supreme Court has ruled.

Responsible for the ruling is a routine regulation of the University

of Washington that requires all students to submit to a chest X-ray. The father of co-ed Dayis Holcomb, a Christian Scientist, had objected to this requirement on the ground that it violated his daughter's religious conscience and constitutional rights.

Judge Ralph O. Olson, writing the court's majority decision, maintained that the protection of the student body as a whole "is of more importance than the right of appellant which is infringed."

Asks Revision of Federal Health Programs

To help trim down the huge Federal health bill, Elmer B. Staats, assistant director of the Bureau of the Budget, is continuing to urge "a complete and systematic review of all Federal grants for promoting health."

Of its total annual budget of $70 billion, the Federal Government is now spending almost $2 billion for health and hospital programs (most of it for veterans and military services). The $2 billion Federal outlay, according to Staats, appears to be substantially greater than the combined total spent on health by all state and local governments. He notes, in this connection, that Uncle Sam operates nearly 20 per cent of all U.S. hospital beds.

To save some of this money by making Federal grants-in-aid more economical and effective, Staats has suggested these improvements:

¶ Existing piecemeal programs should be consolidated into broader programs.

¶ Grants should be more definitely related to the states' needs and resources.

¶ Objectives of the programs should be expressed in terms of *results to be achieved* rather than of *dollars to be spent.*

Besides revaluating health grants in terms of specific objectives, Staats would also have them appraised to determine "whether the amounts devoted by the Federal Government . . . are at least roughly proportionate to the national interest in each of these programs."

Now that defense spending has priority, Staats predicts that in 1952-53 "expansion of basic Federal health programs will be limited to those contributing to national defense." Thus the growth of health services that might have been possible under more favorable conditions "will be slowed down considerably."

They Can Pay Their Bills, Says George Gallup

If you wonder whether rising prices have squeezed out your patients' last nickel (as some editorials say) or whether rising wages are making them rich (as other experts claim), you will be interested in a recent Gallup survey.

Families were asked two questions: One of the questions ("What is the *smallest* amount of money a


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family of four needs each week to get along on?") revealed the predictable news that the sum needed is about twice what it was fifteen years ago.

More startling were the answers to the second question ("Is your total weekly income larger or smaller than the amount you named as the minimum?"). Only 22 per cent of those queried complained that they have less money than they need; 58 per cent reported more-than-adequate incomes.

Doctors Refuse Role In Hospital Strike

Should a medical society cooperate with organized labor to ease the effects of a possible hospital strike? Emphatically not, says the San Francisco Medical Society, which was recently invited to help in planning for just such a contingency.

In its invitation, the union had suggested that the society delegate three members to a labor-sponsored committee. The committee's duties: to prepare for emergencies in San Francisco hospitals if "by reason of a breakdown in negotiations, the interruption of services . . . is imminent."

Said the society's president, Garnett Cheney, in his reply: "The San Francisco medical society does not recognize that any conflict between management and labor can be of such magnitude that its attempted solution should in any way justify jeopardizing to the slightest degree the proper medical, nursing, dietary, pharmaceutical, and hospital care of sick patients."

Attempt to Set Fees for Surgery Assistants

What are "ethical and reasonable" charges for physician-assistants and physician-anesthetists taking part in surgical procedures?

At least as far as Illinois is concerned, there need be no further confusion. The state medical society has adopted this resolution:

"Reasonable and legitimate expenses of any physician practicing in the State of Illinois [have] been, and should continue to be, $25 per hour for physician assistants, and $25 per hour for physician anesthetists at operations."

A Tax Gambit to End Hospital Deficits?

An imaginative new scheme to end hospitals' deficits would utilize a tax-exempt pension fund, to channel money into the hospital treasury; the fund would be built up from the dollars that staff doctors would ordinarily have to pay out in income taxes. This plan has been advanced by Samuel Horwitz, attorney for (and a trustee of) Cleveland's Mt. Sinai Hospital.

Using as an example a doctor who has a hospital-connected income of $25,000 and must pay a 1951 Fed-

eral income tax of $7,230, Horwitz explains his plan in five easy steps:

(1) The hospital charges the doctor a sum equivalent to his income tax for the use of the hospital's facilities.

(2) This leaves the hospital, for the time being, $7,230 richer. It also leaves the doctor with the same $17,770 he would have had after paying his regular tax.

(3) The doctor then pays income tax on the smaller income of $17,770; what with the lower tax bracket, this comes to only $3,592.

(4) The hospital next compensates the doctor for his tax check by paying a like amount—$3,592—into a tax-exempt pension fund.

(5) After tucking $3,592 into the doctor's cookie jar, the hospital—which has just received his $7,230—still realizes a $3,638 profit out of the transaction.

The idea, Horwitz contends, will benefit both hospital and physician. The hospital will pocket cash that would otherwise have gone to the Government. The doctor will net the same income as before—and will probably welcome the compulsory

Anecdotes

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savings made in the pension fund.

As to Uncle Sam's part in the scheme, Horwitz musters this ingenious argument: "Under the existing set-up, a hospital's deficit is made up by private contributions, which are tax-exempt. If the hospitals were self-sustaining, donations would not be necessary, and the sum represented in them would be subject to levy. Thus, while losing one source of revenue, the Government would gain another."

He Hopes They Won't Charge Malpractice

While Dr. B. A. Smith of Spencer, W. Va., was delivering a baby girl to a couple in their teens, the excited young father accidentally set his hog pen on fire.

Later on, Dr. Smith, who is Spencer's oldest practicing physician, submitted a somewhat apologetic birth report to the town newspaper: "I saved the baby, the mother, and the daddy; but I lost the hog."

Blue Cross Sets Rosy Enrollment Goal

With 41 million Americans already under its wing, Blue Cross now sees the sky as the limit. According to Richard M. Jones, director of the Blue Cross Commission of the American Hospital Association, an eventual membership of 140 million—"all but the 10 million . . . indigent"—is by no means impossible.

"The Blue Cross objective of almost universal enrollment," says Jones, "has only one real barrier on its road to the future—the human equation. If all of us concerned understand and agree on the objective, there is no real reason why it cannot be achieved."

Yeshiva Medical School Throws the Book Away

"We intend to break down the different barriers that now separate the medical subjects." This is the pledge of Dr. Harry M. Zimmerman, director of Yeshiva University's soon-to-be-built medical school.

The new Bronx (N.Y.) institution, which is to be the first unit of a proposed $25 million medical center, will probably be ready to receive its first students in the fall of next year. And if Harry Zimmerman puts his theories into action, it promises to be a place worth watching. Among the numerous planned innovations:

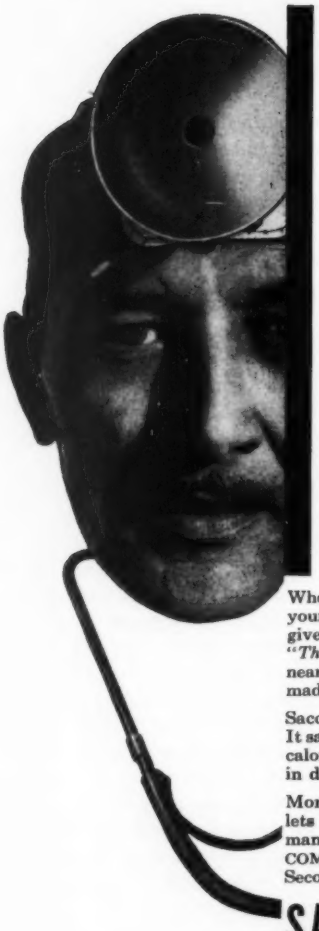
¶ Clinical teaching, almost from the first day, in conjunction with preclinical studies;

¶ A de-emphasizing of narrow specialization (anatomists and bacteriologists, for example, to be appointed to the surgical department, surgeons to other divisions);

¶ A flexible curriculum, with an early effort to correlate all subjects;

¶ Training in the principles of economics and their practical effect on family and community health;

¶ Seminars on the various types



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of prepaid medical care and group practice;

¶ An organized course in ethics, stressing the behavior of the physician as a member of society;

¶ A developing concentration on new types of medical practice, such as home-care programs for the aged and chronically ill.

Dr. Zimmerman visualizes Yeshiva as a potential center for the study of preventive and legal medicine. Medico-legal subjects—including orientation in the legal rights and duties of the M.D.—will be taught, he says, at an experimental "courthouse" on hospital grounds.

Yeshiva was founded in 1897. It attained university status in 1945. Its medical school will be a non-sectarian one under Jewish auspices.

Specialists Asked to Be Less Aloof

"Is there a doctor in the house?"

It's good public relations to answer this call—even if you *are* a specialist and the case is "much less of an emergency than the patient or his friends imagine."

This is the suggestion of the Colorado medical society, whose Board of Supervisors (grievance committee) has heard of incidents in which physicians with narrow specialties have declined to give first aid. The board asks the society's members to reread the following lines from the Principles of Medical Ethics:

"A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service."

Praises Blue Shield's 'Magic of Averages'

If you have felt like protesting what may seem to be inadequate payments from Blue Shield, you might do well to remember the principle underlying those payments, says James E. Bryan, administrator of the Medical-Surgical Plan of New Jersey. That principle, he points out, is the law of averages; and Blue Shield fees for specific services are "average payments, based upon the medical profession's own estimate of the average amount that could be paid for such services by people in income brackets under $5,000 a year."

In private practice, Bryan adds, "the fee that a professional man receives for his service usually represents some sort of compromise between what he would like to receive and what he knows the patient can reasonably be expected to pay."

Blue Shield fees *are* the compromise. "If a surgeon performs the same operation on four different patients and collects $200 from one, $150 from another, $50 from the third, and nothing at all from the fourth, he has realized a total of $400 for all four services. But if Blue Shield pays him $100 for each of these operations, he has realized

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just as much—and he has encountered no problems of negotiation or collection."

There is, says Bryan, a further (if less obvious) saving to the doctor in that he is paid for his services to many families who might otherwise have qualified for free medical care in a hospital ward. And, as the clinching argument for those doctors who still continue to grumble, Bryan quotes Winston Churchill, who once called this type of insurance "the magic of averages applied to the salvation of the multitude."

M.D.'s Disarming Ways Subdue Ruffian Cop

What would you do if you saw the car ahead of you swerve uncertainly from side to side? You might assume the driver was ill and offer him your help. But what (next question) would you do if the "sick man," actually a policeman in his civvies—and in his cups—began to hurl verbal and fistic abuse at you and to threaten you with his service revolver?

Julian Rosenthal, Bronx (N.Y.) physician, returning from a night call, was confronted recently with both problems. He solved them neatly by (1) throwing a few punches of his own, (2) disarming the policeman, and (3) delivering him to the station house.

"It was all in the day's work," Rosenthal commented later. "Complaint? No, I didn't file a complaint against the man. They told me he has two children, one of them only a month and a half old. He'll have it tough enough without me."

New Interstate Compacts Aid Medical Training

Medical-education horizons have begun to brighten in some hitherto neglected sections of the U.S. The reason: Groups of Southern and Western states, agreeing to interstate compacts that disregard state lines, have at last decided to pool their financial resources and training facilities.

One such group, the Western Interstate Commission for Higher Education, which comprises eleven states plus Alaska and Hawaii, has announced that it is now ready to go into action. Another, the Southern Regional Education Board, is already in full swing.

Under the compact, each state government pays an agreed sum for the education of students accepted by out-of-state schools. For 1951-52, the eleven participating states of the Southern group distributed over a million dollars to eight medical schools.

Part of this money helps the schools to meet increasing costs. But nearly half the current year's funds is being used to pay for the education of 363 medical students.

The compact has brought benefits all around. One striking example: Meharry Medical College, a

Nashville (Tenn.) institution for Negroes which faced closing, has been enabled to continue operations.

Schools also report a sharp upswing in the quality of students—possibly because of the establishment of quotas of students from particular states. According to the Governor of Florida, which has no medical school of its own, the compact is "the greatest bargain since manna fell on the children of Israel."

Would Broaden Programs Of Medical Meetings

Do you feel that speakers at medical society meetings are "talking down" to their listeners and that there isn't enough give-and-take of opinion between platform and floor?

That's the way things are, at least in Pennsylvania, says Dr. Max H. Weinberg. To be sure, there usually is a question period at the end of county meetings. "But except for special occasions, when the subject is new and dramatic (as, for instance, ACTH or cortisone), there's not a 'peep' from the audience."

Writing in The Pennsylvania Medical Journal, Weinberg complains that the situation is even worse at state meetings. There, he says, programs are scheduled from a "Papa-knows-best" point of view, and they seldom provide time for discussions from the floor.

What's the answer? Dr. Weinberg suggests that chairmen schedule occasional round-table meetings to give more M.D.'s a chance to express themselves and compare notes. Members should also be encouraged to present papers of their own, he says; for, although guest speakers are a good thing, "too much of even a good thing is not altogether desirable."

Doctors Fight City Tax On M.D.'s—and Win

Slapping a $100 annual license fee on each of its "rich" doctors seemed like a good revenue-raising idea to the New Kensington (Pa.) city council. But unfortunately—for the city—the doctors disagreed.

Thirty local physicians appealed to the courts, and Judge George H. McWherter has ruled in their favor. Disallowing the city's claim that its levy was merely a "registration fee," he terms it a tax. And, he points out, since doctors already pay a state license fee, they can't be taxed twice.

Small Towns a Bonanza For Young Doctors

Small towns need medical help, and they are in a position to pay for it. Once again this fact has been strikingly illustrated—this time by an Iowa survey of the state's doctor-shortage. The survey has turned up, among other things, one particularly illuminating case history:

Young Dr. Charles P. Hawkins ran an ad in the state medical jour-

nal to find a place to locate. The ad pointed out that with four years of army service behind him, he was not likely to be called into service again.

Replies? He got more than thirty of them, and they came from both civic groups and individual doctors. Three towns offered to provide him with a house and fully equipped office on *his* terms. Several physicians tried to tempt him with monthly salaries of up to $800—with a prospect of partnership within a year.

Hawkins made it his business to find out what was behind these letters. "I talked with a representative from one town who guaranteed me $20,600 the first year," he says. "I was skeptical about it, but they *do* have two doctors there. And they're both old."

Some of the doctors who hoped that he would want to work with them opened their books to young Hawkins. Their business figures, he says, show that for a general practitioner in Iowa an annual gross income of $30,000-$40,000 is not uncommon. "I'd say $18,000-$20,000 is probably the average. In Iowa any doctor making only $10,000 isn't working hard or there's something wrong with him."

Among the facts revealed by the Iowa survey (and probably applicable to many other sections of the country) which make Charles Hawkins' report credible:

In spite of a heavy population increase, there are fewer doctors in the state today than in 1940. The result is that each of Iowa's 1,343 active family doctors must take care of 955 citizens (almost 200 more than the national average). Some 390 towns have no M.D. at all. And there is another problem in addition to the shrinking number of physicians; the doctors themselves are getting superannuated: 29 per cent are over 60 years old.

D.P. Physicians Get Break in Michigan

Michigan has found a way to ease its doctor shortage: D.P. physicians who have lived in the state since June 14, 1951, may soon be permitted to practice medicine there. They won't have to go back to school, either, in order to qualify for the state examination.

The medical schools of the University of Michigan and Wayne University have been authorized to set up a screening program to determine which of the state's present complement of about sixty D.P. physicians are eligible to take the exam. The 1951 base line has been established to prevent a sudden influx into the state of alien M.D.'s.

Spokesman Cites Labor's Health Insurance Aims

What this country needs is a compulsory national health insurance program that will provide free choice of practitioner—including os-

Terramycin Nasal

(with desoxyephedrine HCl)

Well tolerated by the nasal mucosa, Terramycin Nasal (with desoxyephedrine HCl) offers both wide-range topical antimicrobial action and mild but prolonged vasoconstrictor effect in the local treatmen of acute rhinitis, vasomotor rhinitis and nasopharyngitis. Terramycin Nasal (with desoxyephedrine HCl) may be administered by atomizer, as original drops, or in gauze packs without adversely affecting ciliary action. For best results administer at the earliest symptoms.

the only broad-spectrum antibiotic available as nasal drops

supplied: Convenient 5 cc. dropper vials containing 5 mg. Terramycin as the Crystalline Hydrochloride per cc. with 0.25% desoxyephedrine HCl, buffers and aromatics.

Pfizer *World's Largest Producer of Antibiotics*

ANTIBIOTIC DIVISION, CHAS. PFIZER & CO., INC.
BROOKLYN 6, N.Y.

teopaths and chiropractors—and will strongly emphasize preventive medicine. These, says one of its spokesmen, are the goals of organized labor.

"Free choice of doctor," according to President Ed Weston of the Washington State Federation of Labor, means that "the plan must not restrict the availability of medical talent." And medical talent, he says, includes "reputable osteopaths and chiropractors, who are entitled to greater consideration and more courteous treatment than they now receive."

Labor's desire for "preventive medicine, early diagnosis, adequate treatment, and also the improvement of quantity and quality of medical facilities" should not be misinterpreted, says Weston. It "does not mean socialized medicine; for . . . labor in this country has not endorsed socialized medicine." But he warns doctors that the Government will eventually take matters into its own hands "unless you get there first!"

Red Cross vs. Medical Blood Banks Again

A fresh salvo in the fray between organized medicine and the American Red Cross over blood banking has been fired by Norman Thomas, perennial Socialist candidate for President.

In a letter to the New York Times, Mr. Thomas has accused county medical societies, especially those in Houston and Dallas (Tex.), Minneapolis (Minn.), and Newark and Monmouth County (N.J.), of obstructing blood collections by the Red Cross and opposing the opening of new Red Cross blood banks.

Inquiry in the areas cited by Thomas seems, however, to have turned up few really serious difficulties—a rather gratifying situation, in view of the deep difference of opinion between the two groups. One of the supposed county-society culprits, in fact, cites a testimonial letter from the executive director of the local Red Cross chapter, which concludes:

"May I express the deep appreciation of the Monmouth County Chapter of the American Red Cross for the fine cooperation of the Monmouth County Medical Society both in the past and present."

And national officers of the Red Cross, for their part, point to a telegram received recently from Dr. George F. Lull, general manager of the A.M.A.: "The American Red Cross is to be congratulated for its coordination of the nation's blood bank program since its inception four years ago . . . America's physicians renew their pledge to do everything possible to make the blood program a continuing success this year and in the years to come."

The only locality where some foundation may possibly exist for Norman Thomas' charges is Houston. The Harris County Medical Society has long objected to what it consid-

Therapy for Vascular Headache to Reverse the Physiologic Disturbance

Headache, a problem encountered in all kinds of medical practice, may occur in association with any of a variety of disorders, some organic, others purely functional.

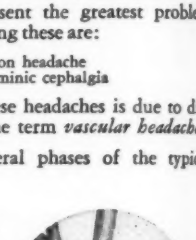
Among the several types, functional headaches present the greatest problem because of their obscure etiology and recurrent nature. Among these are:

Migraine (both classical and variant forms)
Psychogenic headache
Tension headache
Histaminic cephalgia

Wolff and his co-workers established that the pain of these headaches is due to disturbance of the tonus of cranial blood vessels — hence the term *vascular headaches.*

The craniovascular changes associated with the several phases of the typical migraine attack are:

Vasoconstriction—to which the visual prodromata are attributable. It is possible to abort the attack during this phase in all but a few cases. (See treatment below.)



VASOCONSTRICTION

VASODILATATION

Vasodilatation — as the vessels lose their tone, exaggerated pulsations set in, resulting in the throbbing pain which characterizes vascular headache. Treatment for the attack is still effective during this phase. (See below.)

Vessel Edema — if the vasodilation continues for too long, vessel walls become edematous; this changes the character of the pain to a steady, intense aching. The attack can now no longer be checked, even with maximum dosage of specific drugs. *Moreover, sustained headache often induces reflex neck muscle tension, a source of residual pain.*

EDEMA

Therapy: For maximum success, treatment must follow two lines:

1. Relieve the acute attack — of the numerous drugs which have been tried, ergotamine and its derivative preparations have proved most effective. The *newest product is oral tablets* of Cafergot® N. N. R. (ergotamine with caffeine 'Sandoz'). When dosage is adjusted to the needs of the individual, Cafergot will give good relief in 85% of cases. It enables a greater number of patients to benefit from early administration since the oral route simplifies treatment as compared to parenteral therapy.

Many migraine patients delay taking medication until the attack has reached its height. Explicit dosage instructions may be forgotten unless the patient is made to realize their importance. To obviate this, the Sandoz Scientific Department has prepared pads of INSTRUCTION SLIPS* which outline dosage procedures in detail for the patient.

2. Reduce the frequency of attacks — psychotherapy and regulation of living habits to avoid fatigue and nervous tension are most effective.

*Pads of INSTRUCTION SLIPS will gladly be sent on request; reprints of recent reports on Vascular headaches also available.

GENERAL REFERENCES: DeJong, R.: Chicago M. Soc. Bull. 54: 106, 1951. Friedman, A.: Modern Headache Therapy, St. Louis, C. V. Mosby Co., 1951. Shofstall, C. and Shofstall, W.: J. Kanasas M. Soc. 52: 366, 1951. Wolff, H.: Headache and Other Head Pain, New York, Oxford University Press, 1948.

Sandoz Pharmaceuticals

DIVISION OF SANDOZ CHEMICAL WORKS, INC.

ers Red Cross interference with matters rightfully under the jurisdiction of private medicine. Houston is, indeed, one of the few large cities that had no Red Cross blood bank even during World War II.

Here is Houston's point of view, as expressed by one of the city's leading physicians:

"Blood is a therapeutic agent. As such it is a concern of the medical profession. If therapeutic agents, either in production or in use, come under the domination of Government or 'social' agencies, less and less control by the profession will be inevitable. We may then expect to lose control of the following in this order: blood, antibiotics, eyeglasses, false teeth, surgical operations."

As the Houston society sees it, the Red Cross refuses to draw on already existing banks and seems to "prefer to establish its own regional banks, the purpose of which is not only to draw blood for the armed services at the taxpayer's expense, but to draw blood from volunteer donors, process it at the expense of generous financial donors, then give it without charge to whoever needs it. This is a give-away program, and is designed for peace as well as war. We do not feel that such a program is justifiable in any country, nor that a county medical society should tolerate it when a blood-banking program can be an entirely self-supporting private enterprise."

After the start of the Korean conflict, the absence of a blood bank in Houston came under sharp attack by the local press. Names were called, and accusations and counter-accusations flung. Life magazine joined the fracas by singling out Harris County for special censure in one of its "Letters to the Editor" columns.

In return, the Houston society charged that the Red Cross had been dragging its feet. As long ago as November, 1950, according to spokesmen, the Harris County society approved a Red Cross center, which was to begin speeding blood from Houston donors to Korea within sixty to ninety days. But nine months later, they said, the Red Cross had failed to put the program into effect. Thereupon, the society withdrew its original support and set up a privately operated, nonprofit blood bank.

Comments the Red Cross tersely: "We were invited by local medical and hospital authorities to open a regional blood center. Due to unavoidable difficulties in securing a suitable building and technical personnel, its opening was delayed. Then the attitude of the Harris County Medical Society changed, so that no regional center was ever opened."

There has been an uneasy truce since. The Houston bank has a contract with the national Red Cross through which Houston now provides a weekly supply of 250 pints of blood for the armed forces. The

local Red Cross chapter acts as a recruiting agency for donors.

As a result, the Harris County society can now be said to participate in the national blood program of the American Red Cross. But the society has gone on record as still heartily disagreeing with the principle of the thing.

Progress Report Lauds Water Fluoridation

After five or more years of actual operation in communities from Texas to Canada, fluoridation of public water supplies has proved its value, according to the American Dental Association.

In Wisconsin alone, almost 100 cities and towns have put the plan into effect, says Francis A. Bull, dental health director of the state board of health. No valid objection to fluoridation has been made to stick, he adds; so the measure ranks with "such great public health programs as pasteurization."

Pamphlets for Laymen Aid the Profession

Public relations is largely a matter of public *information*, one of the leading P.R. experts maintains. In line with this thinking, there is a growing assortment of medical booklets and folders. Three good recent examples:

¶ "Man to Man," published by the American Heart Association. Breezily written, the leaflet assures the reader that "just because the

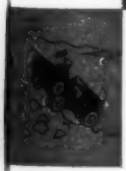
Conducive to normal repair"

Chloresium Ointment and Solution (Plain)

"Without reservation it may be stated that CHLORESIUM *. . . was soothing, non-toxic, and an active agent in restoring affected tissues to a state conducive to normal repair. . . ."*[1]

A growing volume of published reports confirms the efficacy of CHLORESIUM OINTMENT and SOLUTION (Plain) in the topical therapy of resistant lesions. Here are a few comments from recent investigations:

an extensive crush injury of the hand provides ". . . an instance of effective healing under CHLORESIUM therapy, following an apparent failure to respond to skin grafting."[1]



a pilonidal cyst wound—unhealed four months after excision of the cyst with exteriorization—showed "complete healing . . . after use of the chlorophyll [CHLORESIUM] ointment for twelve days."[2]

CHLORESIUM OINTMENT—1-ounce and 4-ounce tubes
CHLORESIUM SOLUTION (Plain)—2-ounce and 8-ounce bottles

CHLORESIUM OINTMENT and SOLUTION (Plain) contain water-soluble derivatives of chlorophyll "a" as standardized in N.N.R. These derivatives, concentrated and highly purified, provide the optimum therapeutic benefits obtainable from chlorophyll.

1. Lowry, K. F.: The Management of Resistant, Non-Healing Skin Lesions: A Report of Three Cases, Postgrad. Med., to be published.
2. Niemiro, B. J.: Delayed Healing in Pilonidal Cyst Wounds, Journal Lancet, *71*:364, 1951.
3. Combes, F. C.; Zuckerman, R., and Kern, A. B.: Chlorophyll—Its Use in Topical Therapy, New York State J. Med., to be published.

RYSTAN COMPANY, INC • Mount Vernon, N. Y.

Rystan

doctor says a man has heart disease, it doesn't mean he's going to drop dead," any more than a doctor's recommendation for glasses means his patient is going blind. The folder is designed to be given to heart patients by their physician.

¶ "Facts You Should Know About Health Cures," one of the Better Business Bureau series. The booklet exposes bogus treatments for such ills as the tobacco habit, flat chest, kidney disease, and cancer.

¶ "Welcome to Des Moines," prepared by the Polk County (Iowa) Medical Society. The four-page folder describes Des Moines' medical facilities, tells where to call in an emergency—and, in the process, helps to save time and steps for Polk County M.D.'s.

Urges Triple Check on Dope Prescriptions

New York physicians will write prescriptions for narcotics in triplicate and on state-issued forms, if a plan proposed by State Senator Seymour Halpern becomes law.

Serially numbered and printed on tamper-proof paper, copy No. 1 would, according to Halpern's plan, be retained by the prescribing physician, No. 2 filed by the druggist, and No. 3 sent to the New York State Department of Health. These records would make it possible for the state to keep close track of both inventories and distribution of narcotics.

The senator is proposing this measure to strengthen state controls

and establish a "forgery-proof" system of prescriptions. Much of the illict stuff now in circulation, he says, was stolen or sidetracked from legal stocks.

Red Infiltration Into Medical Profession?

A correspondent of the Chicago Tribune claims that nine physicians have been identified as Communist Party members in the Los Angeles area alone. According to his story the House Committee on Un-American Activities was given this information at a recent hearing.

Members of the medical profession, the Tribune correspondent adds, have been called a highly desirable catch for the Communist Party. One reformed Red has outlined the services that a physician turned subversive might render to Moscow. He suggests, for instance, that the doctor's office could act as an undercover message center for the party.

Other ex-Communists have testified that the Red set-up would certainly be aided if doctors could be persuaded to stir up racial unrest in hospitals.

Is Your Grievance Group Really Doing a Job?

Some medical societies are learning that the mere existence of a grievance committee gives no assurance that doctor-patient differences will be effectively cleared up. Take, for instance, the situation in Lo

fats ... and figures on fats in infant feeding

LIPID COMPONENTS FATS (gm./100 ml.)	MATURE HUMAN MILK			
	No. determ.	Mean	Min.	Max.
	91	3.2		
		3.8		
	30	3.3	1.1	7.6
	37	4.2		
	7	3.9		
	1154	4.0	0.7	8.0
	7	3.8	2.3	6.8
	27	4		
	45	3.2	3	5
	408	3.4	1.0	6.2
	184	4.0		
	5	2.9	1.3	
	94	3.2		8.3
	1004	3.3	2.7	
	26	3.1	0.5	8.4
		3.3		9.0
			1.9	
				4.6

A breakdown of over 3,000 samples of human milk obtained from hundreds of "representative healthy" mothers,* showing mean fat values, as well as the maximum-minimum ranges.

(From Bull. of the National Research Council, No. 119, January 1950)

the fat content of reliquefied **SIMILAC**

3.35%, closely approximates the average mean value for well-nourished mothers' milk.

but the similarity doesn't end there

Qualitatively, the fat of Similac corresponds closely in physical and chemical properties to the fat of mother's milk. The high level of unsaturated fatty acids, the uniformly small globule size and the increased essential fatty acids approximate those of breast milk. Thus Similac, like breast milk, affords easy digestion of fat, good fat retention, and encourages freedom from gastrointestinal disorders and from dermatologic complications due to low essential fatty acid diet.

Similac is available as Powder, 1 lb. tins, and Liquid, 13 fl. oz. tins

* The mother whose nutritional state is below par frequently produces milk with low fat values.[1, 2] In one large series of poorly nourished mothers the average dropped to 2.9%, with 10% of cases below 2.1%.[1] The fat content of Similac approximates that found in milk of well-nourished mothers. It is consistent and unvarying, always adequate, a fact to remember when breast feeding is not feasible.

Similac is so similar to human breast milk that there is no closer equivalent

1. Müller-Stephens, H.: Zeit. Kinderheilk. 61:498, 1940.
2. Sahni, T.: Acta Paediatrica: 33:1, 1944.

M & R LABORATORIES
Columbus 16, Ohio

Angeles, where Dr. Paul D. Foster, editor of the county medical society bulletin, has proposed some sweeping reforms.

According to Foster, the Los Angeles society receives up to 100 letters of complaint a month. Under the present inadequate set-up, he says, most cases are handled by means of letters and telephone calls, with a "virtual absence of the personal element." Final disposition of each case is in the hands of a committee; but it meets only once a month, is sometimes only one member strong, and has a large backlog of unattended cases.

Dr. Foster feels that this overcasual arrangement negates the purpose of the grievance committee "to see that the public interest is fairly and honestly served and to correct misunderstandings and abuses which the patients think have occurred."

To better conditions, he recommends these measures:

¶ Preliminary screening of each complaint through the society's executive secretary or its legal counsel;

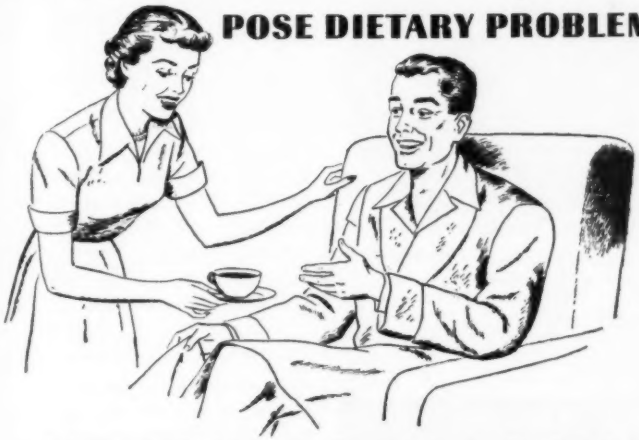
¶ If, after this procedure, the patient remains unsatisfied, a transfer of his case to "a committee made up of retired or semi-retired physicians with the proper amount of time to devote to such worthwhile projects";

¶ Increase of the size of the grievance committee, to assure that complaints will receive "more than one man's attention."

Poorly handled complaints, says Paul Foster, can have a particularly

When Functional Derangements

POSE DIETARY PROBLEMS



In the interest of maintaining good nutrition in the patient, many functional derangements of the gastrointestinal tract make the use of a well rounded dietary supplement, such as Ovaltine in milk, highly advantageous. Among the functional derangements more commonly encountered are nausea, anorexia, gastritis, diarrhea, dysentery, enteritis, and colitis.

In these conditions, Ovaltine in milk is particularly useful, not only because of its easy digestibility but also because of its blandness and its high nutrient content. It offers the opportunity of providing a balanced fare of essential nutrients without mechanical irritation or excessive digestive demands. Hence it qualifies especially when customarily eaten foods are contraindicated and a nutritious bland diet is required.

The wealth of nutrients supplied by three glassfuls of Ovaltine in milk is outlined in the table below.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

Ovaltine

Three servings of Ovaltine, each made of ½ oz. of Ovaltine and 8 fl. oz. of whole milk, provide:

PROTEIN	32 Gm.	VITAMIN A	3200 I.U.
CARBOHYDRATE	65 Gm.	VITAMIN D	420 I.U.
FAT	30 Gm.	ASCORBIC ACID	30 mg.
CALCIUM	1.12 Gm.	NIACIN	6.7 mg.
COPPER	0.7 mg.	PANTOTHENIC ACID	3.1 mg.
IODINE	0.7 mg.	PYRIDOXINE	0.6 mg.
IRON	12 mg.	RIBOFLAVIN	2.0 mg.
PHOSPHORUS	940 mg.	THIAMINE	1.2 mg.
CALORIES	658		

Two kinds, Plain and Chocolate Flavored. Serving for serving, they are virtually identical in nutritional content.

vicious effect on patient-physician relations. "If our grievance committees cannot act to enhance public relations," he says, "then no grievance committees should exist at all."

Coal Miners' Wildcat Strike Ousts Doctor

In a wildcat strike, union miners in the Utah coal region have forced: (1) the mines to fire an industrial physician, and (2) the physician to sell his thirty-bed hospital to the mining companies. The doctor is Frank V. Colombo, 38, who won national attention through his heroic part in the rescue operations following a 1945 mine disaster.

The conflict started last September, when the United Mine Workers' welfare fund dropped Colombo from its panel of physicians "because of certain practices and the size of fees demanded." After the ouster, Colombo, in addition to continuing as industrial physician for a mining region with a population of 7,000, set up a health insurance program of his own. As owner and operator of the Dragerton Hospital, he provided family hospitalization, surgery, obstetrics, house calls, office calls, and drugs at a cost of $10 a month.

This put him into competition with what one observer called "a less desirable plan" offered by the union. According to this same source, the popularity of the Colombo plan "made the union plan look bad, reducing the union's bargaining prestige." As a result, officials of the local

IN HARASSING DERMATOSES

HISTARx

TRADE MARK

Three years of clinical study have established the efficacy of Histar in

Neurodermatitis
Urticaria
Papular Urticaria
Allergic Rashes
Allergic Eczematous Dermatitis
Atopic Dermatitis
Dermatitis Venenata
Psoriasis with Allergic Component
Idiopathic and Secondary Pruritus Ani, Vulvae, and Senilis

FOR PROMPT SYMPTOMATIC RELIEF AND HIGH THERAPEUTIC EFFICACY

Histar, a true achievement in dermatologic therapeutics, presents a combination of pyrilamine maleate, 2 per cent, and an extract of carefully selected crude coal tar (Tarbonis brand), 5 per cent, in an emulsified hydrophylic base, non-greasy and clean in application. In harassing skin conditions, burdened with tormenting burning and itching and refractory to other treatment, Histar has proved of high therapeutic value.

A POTENT LOCAL ANESTHETIC

Pyrilamine maleate, a potent yet relatively nontoxic, nonirritant antihistaminic, neutralizes the excessive histamine released into the affected tissues by dermatoses with allergic components; thus it quickly overcomes the associated burning and pruritus. Furthermore, it is reported to be a powerful local anesthetic 3.3 times as potent as procaine.*

DECONGESTANT . . . ANTI-INFLAMMATORY

The contained tar extract in Histar rapidly improves the lymph circulation in the skin and lessens the edema accompanying local pathology, thus aiding the normal defense forces of the tissues.

PHYSIOLOGIC SYNERGISM

The two therapeutic agents in Histar not only appear to potentiate each other, as indicated by their greater efficacy when applied in this combination, but their actions complement each other and stimulate and enhance the natural defense mechanism of the body, in histamine neutralization and absorption and removal of offending infiltrates and exudates.

Histar is available on prescription through all pharmacies, in 2 oz. jars; for dispensing, in 1 lb. jars through surgical supply dealers. Physicians are invited to send for literature (clinical background) and samples.

*Dews, P. B., and Graham, J. D. P.: Antihistamine Substance 2786 R.P., Brit. J. Pharmacol. *1*:278 (Dec.) 1946.

THE TARBONIS COMPANY

4300 Euclid Avenue • Cleveland 3, Ohio

branch of the U.M.W. called the strike that ended, twenty days later, with Colombo's enforced resignation as company physician.

Dr. Colombo intends to remain in the locality and "carry on in private practice." The Dragerton Hospital, no longer his, will be run by union-approved physicians.

City's Gift to Newborn: Health Record Booklet

Parents of babies born in Providence, R.I., in 1952 and thereafter will have no trouble keeping track of their children's health records. A sixteen-page permanent record booklet is now being issued to all new parents with the compliments of the city health department.

The booklet is about the size and shape of a folded lease or insurance policy, and it's meant to be stored with such documents. It provides space for:

¶ Pregnancy, delivery, and birth data;

¶ Records of immunizations, illnesses, accidents, operations, and general growth and development;

¶ Pre-school physical examination and general health notes;

¶ Physical examinations and progress notes from kindergarten through the twelfth grade.

The booklet, with all its entries, is to be retained by the parents. Thus, if the family moves away or changes doctors, it takes with it a complete and undistorted medical history of the youngster.

Joint brain-child of Rhode Island's

medical society, the Providence Medical Association, and the superintendent of health, the health record will be sent to an estimated 15,000 families in 1952. It should, say hopeful medical men, "tend to stimulate and improve the patient-physician relationship."

Local Banks Finance Hospital Accounts

Hospitals are coping more and more satisfactorily with the problem of getting cash on the line instead of in long-drawn-out, piecemeal payments from patients. The most recent example of this comes from Newton Lower Falls, Mass.

There, the Newton-Wellesley Hospital has entered into an agreement with local banks whereby the banks finance patients' accounts at moderate cost to the patients themselves. The arrangement is simple:

The patient applies for the loan (from the local bank of his choice) at the hospital's credit office when he's being discharged. The hospital forwards his application to the bank, which then pays the bill in full. All further dealings are between the bank and the patient. In most such cases, therefore, the hospital has no accounting and collection problems.

The result? "Many times we have seen utter relief when the patient or his relatives were told that the account could be paid on an installment basis," reports Elmer C. Gould, chief accountant of the hospital. At other times, he says, "patients who claimed inability to pay

SEAMLESS

PRO-CAP

ADHESIVE PLASTER

1 – *Sticks Easily and Well*
2 – *Causes Little or No Irritation*
3 – *Does Not Slip or Creep*

Because — Fatty acid salts in the mass—zinc propionate and zinc caprylate—reduce skin maceration and slimy deposit and retard the growth of bacteria and fungi. Write for results of clinical tests.

Prove it to Yourself —

Write for a FREE spool of Pro-Cap. If you are irritated easily by plaster, make a side-by-side patch test on your forearm using Seamless Pro-Cap and any other adhesive plaster. Leave tape on 48 hours—see the difference! Prove to yourself that Seamless Pro-Cap causes little or no skin irritation.

SURGICAL DRESSINGS DIVISION

THE SEAMLESS RUBBER COMPANY

SEAMLESS

suddenly decided that they could pay the hospital in full when they were told that the credit manager could make arrangements for a bank loan."

Apart from providing the hospital with extra, ready cash, the plan described puts financial dealings between hospital and patients on a thoroughly businesslike basis. It also relieves hospital personnel of much clerical work.

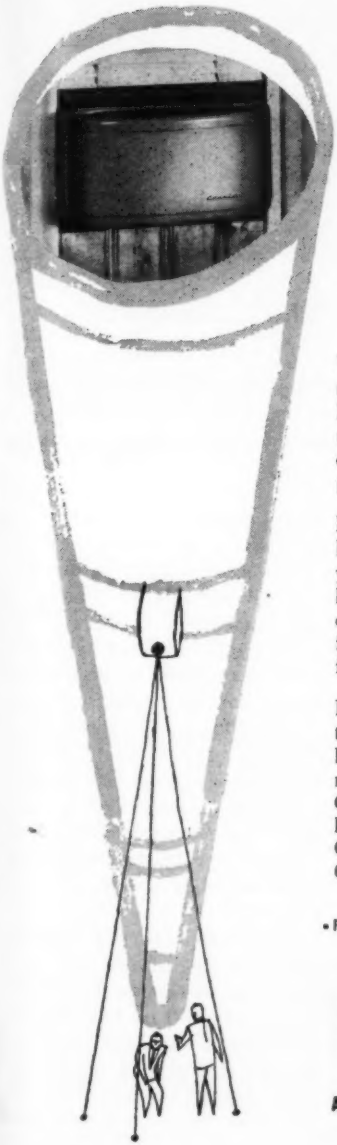
Each note is endorsed by the hospital; and if a patient defaults on his payments to the bank, the hospital assumes any unpaid balance.

This last stipulation amounts to less of a drawback than might be assumed. Gould, writing in Hospitals magazine, says: "While the defaulted notes have been rather heavy (about 15 per cent), the net result has been one of considerable relief to the hospital . . . " By the end of the first year, according to Gould, the institution expects to have turned over about 25 per cent of all its accounts receivable to the banks. That will have meant about $40,000 of ready cash in the hospital's tills.

Smash! Crash! Tinkle! —Novel Ulcer Cure

"Breaking things eases my nervous tension and averts ulcer attacks," says Edward Smith of Chicago.

Smith has been sued for divorce by his wife, who lists sixty assorted dishes, thirty drinking glasses, and numerous window panes that her



What to look for in a room air conditioner

You're probably familiar with many of the benefits you'll find in a Carrier Room Air Conditioner . . . how it steps up your efficiency, reduces fatigue, cuts down on broken appointments, promotes patient co-operation.

But air conditioning can be a blessing only if it fits the needs of your space. That's why you should be sure to buy Carrier. Because Carrier offers you six models to choose from—one of them just the right size for your air conditioning requirements.

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husband has shattered—along with *her* nerves—within the last year or two.

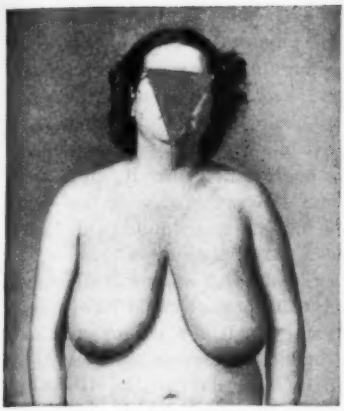
When a divorce-court judge pleaded with the husband to see a doctor instead of using his obviously fragmentary knowledge of medicine, Smith refused. This method of coping with his ulcers was, he argued, a lot cheaper "than paying doctor bills."

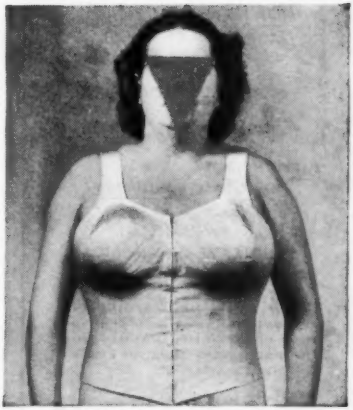
Why British G.P.'s Feel Frustrated

When British doctors comment on life under the National Health Service, the one word that seems to come up constantly is "frustration." So says Dr. S. Wand, a B.M.A. committee chairman, who adds that "this frustration arises because the doctor is so often prevented from doing the best and most useful work of which he is capable.

"I have had reported to me cases of actual violence by the patient against the doctor because the doctor asked for some further information," says Dr. Wand. "The doctor has no redress except in the ordinary courts, but a hasty word by a tired doctor can, and does, lead to a medical service committee inquiry, with all its anxieties and possible publicity."

Or take the matter of unjustified calls. "It is not realized," says Wand, "that a call that comes after the doctor has started on his morning rounds cannot easily be [answered] until the afternoon, or that one coming in after he has started his after-





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noon rounds may not be possible until he has finished a very heavy evening surgery . . . Picture, then, the doctor, after a heavy 11- or 12-hour day, as so often happens in the winter, having to get out his car and drive on a winter's night over ground he has covered already, perhaps many times, that day, to find that the message could quite easily have been sent at the proper time, or, in fact, that a visit was not at all necessary—the patient could have come to surgery. It is a serious waste of valuable professional time.

"In these days of the 40-hour week," says the British physician, "how are you to assess in terms of wear and tear on the doctor the work done in the 70th hour?"

The Fee Wasn't High, But the M.D. Was

The patient must pay for a house call made by a doctor—even when the doctor is obviously feeling no pain—if the patient knows the physician is a habitual elbow bender. This was a New Jersey court's recent answer to a man who refused to pay his doctor's bill because, as he put it, "the doctor was positively drunk when he came to the house. His advice was worthless, and I didn't follow it. In fact, he's been our family doctor for years and he seems to be drunk more often than he's sober!"

The judge declared that since the man knowingly employed (and continued to employ) an alcoholic, he had no legitimate excuse for refusing to pay up.

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SUBJECT INDEX TO

Medical Economics

OCTOBER, 1951—MARCH, 1952

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